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| **PAEDIATRIC FATIGUE SERVICE** | | | |
| **Patient Details** (affix patient label if available) | **Referrer Details:** | | |
| Forename(s) | GP | | |
| Surname | Practice Address | | |
| Address |
| Post Code | Post Code | | |
| Gender | Telephone | | |
| Date of Birth | Email | | |
| NHS No. |  | | |
| **Contact Email address** |  | | |
| **Contact Telephone Number(s)** |  | | |
|  |  | | |
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| **Referral Process and checklist**  The Paediatric Specialist Fatigue service provides assessment, diagnosis and treatment for children and young people who have severe and debilitating fatigue.  In order to refer to our service we require the following **(please ensure all boxes are ticked before sending):**  A referral letter  Copies of relevant reports and assessments  Confirmation that blood tests have been completed within the past 12 months and are normal  A local paediatrician that we can work alongside as we provide treatment or confirmation that a  referral has been made to local paediatrics for an initial assessment for any other causes of fatigue  Confirmation that the patient has been seen face to face by GP if Paediatrics not available due to age  Confirmation that any underlying conditions have been treated for at least 3 months  Details of all agencies involved    Please note that if you require a pain specific intervention, please refer to your local pain clinic or to The Bath Centre for Pain services ([www.bathcentreforpainservices.nhs.uk](http://www.bathcentreforpainservices.nhs.uk)) depending on need and local resources | | | |
| **Referral information** | | | |
| **Attached reports/assessments - Please list** | | | |
| **Name of local paediatrician** | | | |
| **Other agencies/professionals involved** | | | |
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| **The following blood tests must have been carried out within the last 12 months. WE DO NOT NEED COPIES OF BLOOD TESTS, but we do need confirmation that all bloods are normal and if not, what action has been taken** | | | |
| **Blood Tests:**   |  |  |  |  | | --- | --- | --- | --- | |  | **Date of Blood test** | **Confirmation of result within normal limit** | **Abnormal result, action plan comments** | | **Full Blood Count** |  |  |  | | **PV or ESR** |  |  |  | | **C-reactive protein** |  |  |  | | **Urea, Creatinine and electrolytes** |  |  |  | | **Thyroid Function (TSH + Free T4)** |  |  |  | | **Creatine Kinase** |  |  |  | | **Coeliac Screen (TTG)** |  |  |  | | **Ferritin** |  |  |  | | **Liver Function Tests** |  |  |  | | **Random Blood Glucose** |  |  |  | | **Calcium** |  |  |  | | **Vitamin D if patient housebound** |  |  |  |   **Do you think the young person’s fatigue symptoms were triggered by COVID? Yes/No**   |  |  |  |  | | --- | --- | --- | --- | | **Height (cm**) | **Weight (kg**) | **BMI** | **Date:** | | |  |  |
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| If you have any questions or would like to discuss a referral, please contact [ruh-tr.paedscfsme@nhs.net](mailto:ruh-tr.paedscfsme@nhs.net)  or call 01225 821340  To ensure that we can act on your referral promptly, please check that you have included all relevant information before sending. | | | |
| **Signed (referrer):** | **Print name:** | | |
| **Date (dd/mm/yy):** | **Profession:** | | |

This record forms part of a legal document. It must be signed, dated, legible, and filed within the clinical notes section of the patient’s main records.