**DOMICILLARY PHLEBOTOMY REFERRAL FORM**

**The service will support all HOUSEBOUND patients’ [those unable to access alternative phlebotomy services], registered with a Coventry GP**

***All fields must be completed or the form will be returned direct to referrer:***

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Is the patient housebound? |  | Yes |  | No  [please refer patient to clinic-based phlebotomy service] |
| Does/will the patient have a blood form? |  | Yes |  | No |
| Is the blood test Fasting or Non-Fasting?    Are there any risk factors to consider when visiting the patient and/or property? |  | Fasting  Yes |  | Non-Fasting  No |

If yes, please specify:……………………………………………………………………………….

Interpreter Required? [if yes, please specify patient’s first language]?  Yes  No

…………………………………………………………………………………………………………

**Response Required:**

**PLEASE NOTE**:

All urgent requests for same day/within 24 hours should be reserved for admission avoidance cases **ONLY** and will require a referral form to be completed and sent to phlebotomy and followed up with a phone call direct to service to ensure appropriate allocation: **024 76961 380**.

*Please be aware: Any urgent referrals received after 13.00 hours [Mon-Fri] will be automatically allocated to the next day*

Urgent [Same Day] 

Urgent [Within 24 hours] 

Priority [Within 72 hours] 

Routine [More than one week] 

Please provide brief details/clinical indication for blood test**:……………………………………**

**………………………………………………………………………………………………………**

**PATIENT DETAILS:**

|  |  |  |  |
| --- | --- | --- | --- |
| Patient Name: |  | DOB: |  |
| Patient Address: |  | NHS No: |  |
| GP Surgery: |  | GP Address: |  |
| GP Contact No: |  | GP Fax No: |  |

**REFERRER DETAILS:**

|  |  |  |  |
| --- | --- | --- | --- |
| Name and Role: |  | Contact No: |  |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Does contact need to be made with a relative/carer prior to the visit? **(If yes, please complete the below details)** | | | |  | Yes |  | No |
| Contact Name: |  | | | | | | |
| Relationship: |  | Contact No: |  | | | | |

OTHER REQUIRED INFORMATION: ***(Please include key codes or any unavailability/access issues)***

|  |
| --- |
|  |

OFFICE USE ONLY:

|  |  |  |  |
| --- | --- | --- | --- |
| Date Referral Received: |  | Phlebotomy Appointment Date Confirmed: |  |
| Patient informed of date of appointment: |  | | |
| Other information: |  | | |

PHLEBOTOMY TEAM ONLY:

|  |  |  |  |
| --- | --- | --- | --- |
| Date Taken: |  | Contact No: |  |
| Other information: ***(including reason for referral decline as applicable)*** | | | |