|  |
| --- |
| **Referral form for consideration of colostomy following SCI** |
| Patient ID: |
| Date, causation, and details of SCI: |
| PMH, previous abdominal surgery, comorbidities, BMI if known: |
| Current medication: |
| Psychological state, any mental health issues past or present: |
| Details of family and social/work situation: |
| Present bowel management *(what kind of bowel management has been tried, for how long, how successful this has been, alternatives considered)*: |
| Reason for referral for spinal colostomy: |
| Patient expectations of colostomy *(please ensure patient is aware functional bowel issues eg bloating and constipation are unlikely to be resolved by colostomy formation)*: |
| Other relevant information *(eg present/planned bladder management, implants, discharge from hospital plan if an inpatient)*:  **It cannot be guaranteed that colostomy can be performed during inpatient admission, please manage patient expectations appropriately** |

This referral form should be completed by the spinal unit medical team and emailed to:

Mr Branagan, Mr Padwick, Mr Szymankiewicz.