**Stoma Care GP Referral Form**

**Email when completed to chu-ftr.stomacare@nhs.net**

**Date: Time:**

**Patient’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**NHS number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patients Telephone No. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Stoma Type:** Ileostomy Colostomy Urostomy Other

**Reason for referral:**

* Stoma problems e.g leakage/sore skin
* New to area
* Over use of equipment
* General review
* Other­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Past Medical History:**

**Stoma Prescription items:**