Pre-operative haemostasis referral for patients with a known bleeding disorder registered with St. George’s Haemophilia Centre

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| Patient’s Name: |  |  | DOB: |  |

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| MRN or NHS no: |  |  | Bleeding disorder: |  |

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| --- | --- | --- | --- | --- |
| Proposed  Procedure: |  |  | Typical expected blood loss with procedure: |  |

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| --- | --- | --- | --- | --- |
| Hospital: |  |  | Surgeon or practitioner: |  |

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| --- | --- | --- | --- | --- |
| Will the patient require neuraxial analgesia: |  |  | Any other anticipated difficulties or concerns? |  |

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| --- | --- | --- | --- | --- |
| Date or approximate date for surgery: |  |  | Typical duration of inpatient stay for this procedure: |  |

Please email completed forms to: [stgh-tr.stgeorgeshaemophiliacentre@nhs.net](mailto:stgh-tr.stgeorgeshaemophiliacentre@nhs.net)

We require a minimum of four weeks’ notice for elective procedures. For urgent procedures please complete and email this form as above, and additionally phone the haemophilia office on 0208 725 0763 and ask to speak with one of the Haemophilia CNS’s to discuss your requirements.

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| Referrer’s name and position: |  | Date: |
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