Ref:

 **Stoma Review** **Letter**

 *Name of Stoma Care Nurse:*

 *Direct Line:*

*Bleep Desk:*

 *Bleep No:*

 *Main switchboard:*

*Date:*

Dear [Dr XXXX],

**Patient’s Name:**

**Date of Birth:**

**Hospital number:**

**NHS number:**

**Address:**

We are pleased to advise you that we have reviewed the above patient in our Nurse Led Stoma Clinic on [date]. The patient has had [type of surgery] on [date] and currently has a [temporary/permanent] [type of stoma]. The stoma products have also been assessed as part of a clinical review.

This review was (select as applicable):

|  |  |  |
| --- | --- | --- |
| **1** | part of their ongoing review post-surgery  |  |
| **2** | requested by the patient because of unexpected stoma management issues |  |
| **3** | requested by; |  GP |  Dist. Nurse |  Other (state) |

Please find a full report of the stoma review and the monthly prescription requirements below.

**Summary of Review**

We have assessed and confirm the following:

|  |
| --- |
| **Stoma status after review** |
| **Description of the problem/issue presented:** |  |
| **Stoma assessment:** |  Healthy |  Other (state) |
| **Condition of peristomal skin:** |  Healthy |  Other (state)  |
| **Stoma output** |  |
| **Patient independent with their Stoma Care:** |  Yes |  No (state type of support needed)  |
| Any prescription amendments would have been agreed by the Stoma Nurse and patient. Please find an up to date list of the patient’s prescription items on the following page and ensure they are updated on the patient’s medical record. |

|  |
| --- |
| **Additional information** |
| **Any medication advice given:** |  |
| **Any dietary advice given:** |  |
| **Any other comments or advice such as hernia prevention, travel, lifestyle issues, return to work or usual activities of living:** |  |
| **The next review is planned for:** |  | **The patient is aware of this plan:** |  Yes |  No |
| **Patient has been asked to contact stoma nurse to arrange?**  |  or | **Stoma nurse will arrange next review with patient?** |  |

|  |
| --- |
| **MONTHLY Prescription Requirements After Review** |

|  |  |
| --- | --- |
| **Current nominated DAC:**  |  |
| **DAC contact details:** |  |
| **The current stoma products and usage remain appropriate:** |  Yes |  No (state why) |
| **Prescription Items:** |
| **Product:** | **Code:** | **Quantity:** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

If you have any queries regarding this patient, please do not hesitate to contact us on the above number.

Yours sincerely,

[Stoma Nurse]