Ref:

**Transfer of Care** **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:**

Please find enclosed the above patient’s prescription requirements for Stoma Care products. I have arranged for these supplies to be delivered by (please tick as applicable):

|  |  |  |
| --- | --- | --- |
|  *Fittleworth* |  *SecuriCare* |  *Other (please state)* |
| *Contact details:* |  |

I have also requested that [*DAC name*] contact you directly for a prescription. Please be advised that a DAC cannot proceed with an order until they are in receipt of a prescription for the required products. I will continue to review to ensure that these prescription requirements remain appropriate.

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

Yours sincerely,

Stoma Nurse

|  |
| --- |
| **Prescription Requirements** |

|  |  |
| --- | --- |
| **GP name and address:** |  |
| **Diagnosis:** |  |
| **Surgery details:** |  |
| **Type of stoma:** |  | **Temporary:** | □ |
| **Permanent:** | □ |
| **Operation Date:** |  | **Discharge date:** |  |
| **Hospital Consultant:** |  |
| **Prescription Items:** |
| **Product:** | **Code:** | **Quantity:** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

|  |
| --- |
| **Additional information** |
| **Condition of stoma:** |  |
| **Condition of peristomal skin:** |  |
| **Volume and consistency of output to support discharge planning:** |  |
| **Frequency of pouch change:** |  |
| **Any dietary advice given:** |  |
| **Any hernia prevention advice given:** |  |
| **Date:** |  |

Please do not hesitate to contact us if you require further information.