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| **Gastrostomy (GT) Multidisciplinary Assessment and Referral Form** | | | | | | Addressograph, or  Name  DOB  Unit No./CHI | | | |
| **Date of assessment:** | | | | | **Date of GT Insertion:** | | | | |
| Consultant: | | Patient’s location:  Ward  Clinic  Home  Other | | | | | | | |
| **General Points**  **Gastrostomy feeding will address the delivery of nutrition and fluids.**  **It will not address a person’s underlying illness.**  **Gastrostomy is an invasive procedure associated with risks of:**   * Pain * Bleeding * Infection * Inadvertent puncture of an intra-abdominal viscus * Death.   Patients may be frail and may not tolerate the side effects well.  **The risks of a complication are greater in:**   * Severe untreated systemic disease e.g.pneumonia, stabilise patient before GT insertion * Severe respiratory disease (precluding sedation/endoscopy) * Severe neurological disease with risk of imminent deterioration/death * Intracerebral shunt (VP shunt) * Ascites and liver disease with portal hypertension * Peritoneal dialysis * Anatomical abnormalities e.g. intra-thoracic stomach.   **Gastrostomy may not be in the patient’s best interests in the following situations:**   * Patient about to start eating * End stage dementia * Family/Carer/relatives/GP/residential Nursing home disagreement * Where there is a poor prognosis and expected survival measured in days to weeks. | | | | | | | | | |
| **Instructions for staff:**  If this multidisciplinary form is not fully completed then it will be returned to you, as we need all the relevant information. Completion may require input from more than one discipline.  Completed referrals will be discussed at the weekly Complex Nutrition Team meeting and decisions will be fed back via email/trak detailing decisions made and their rationales, and if appropriate which procedure needs to be requested on TRAK.  Where the assessment raises questions about GT insertion on either clinical or ethical grounds, the nutrition nurse specialist (or colleague) will review the patient and discuss with the referring team.  Please note, the spaces for your answers will expand as you complete the form to allow you to give all the relevant informationrequired. | | | | | | | | | |
| Current referral details | Is the patient independent? YES  NO  What is their diagnosis: | | | | | | | | |
| Date of GT referral:  Reason(s) to be referred: | | | | | | | | |
| Any concurrent illness: | | | | | | | | |
| Relevant investigations (attach CT report if available)**:** | | | | | | | | |
| **If the patient is an inpatient** – Date of admission:  Admitted from:  Progress since admission to hospital: | | | | | | | | |
| Previous medical history | Previous CVA? YES  NO | | | | | | | | |
| Previous abdominal surgery? YES  NO | | | | | | | | |
| History of peritoneal dialysis? YES  NO | | | | | | | | |
| Ventriculoperitoneal (VP) shunt? YES  NO | | | | | | | | |
| Any contraindications to the procedure (see general points above): | | | | | | | | |
| Speech and Language Therapy Assessment | Referral date: | | | Date reviewed: | | | | | Swallow present? YES  NO |
| Improvement? | | | | | | | | |
| Dietetic Review | Patient referred to a dietitian? YES  NO | | | | | | | Date referred: | |
| Outcome: | | | | | | | | |
| Has NG tube been passed? YES  NO | | | | | | Is NG tube tolerated? YES  NO | | |
| Weight (kg): | | Height (m): | | | | Lost 10% body weight? YES  NO | | |
| Not eating > 2 weeks? YES  NO | | | | | | MUST score: | | |

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| Haematology  Biochemistry | FBC : | INR: | U+E: | |
| LFT: | | Phosphate: | |
| Magnesium: | | Calcium: | |
| Anticoagulants | Safe GT insertion will require withholding of anticoagulants/anti-platelets as below. Referring team should assess risks of withholding anticoagulation and steps required to overcome these | | | |
| Clopidogrel | | | withhold 7 days prior to procedure |
| Warfarin | | | withhold 5 days prior to procedure |
| Apixaban/Direct Oral Anticoagulants | | | withold 48 hours prior to procedure |
| Heparin/Low Molecular Weight Heparin | | | withhold on the day of procedure |
| Aspirin | | | not necessary to withhold |

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| Capacity and Informed Consent | Is the patient capable of understanding the procedure? YES  NO | | | |
| Completed [Adult with Incapacity Form](http://intranet.lothian.scot.nhs.uk/Directory/PolicyHub/Documentation/Adults%20with%20Incapacity%20Form%202000.pdf) in the patient’s notes? YES  NO | | | |
| Informed consent obtained?  YES  NO | | | Consent form in the patient’s notes?  YES  NO |
| Chest Status | Any chest disease? YES  NO | | | |
| Evidence of aspiration pneumonia? YES  NO | | | |
| On oxygen? YES  NO | | On antibiotics? YES  NO | |
| Fitness for the procedure | Is the patient able to lie flat for minimum of 30 minutes?  YES  NO | Those unable to lie flat due to underlying conditions, may not be suitable for procedure | | |
| Is the patient able to tolerate sedation? YES  NO | Those unable to tolerate sedation, due to underlying conditions, may not be suitable for procedure | | |
| Is anaesthetic support required? YES  NO  If YES, GA  LA | | | |

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| Relatives/ carers | Has the referral been discussed with the patient? YES  NO  Has the referral for GT been discussed more broadly e.g. with relatives/carers?  YES  NO  The Patient Information Leaflet, **‘Tube feeding - making the Decision’** (Oct 2017) from the Complex Nutrition Team/Dietetics, which discusses possible risks and complications. Has this been provided to the patient/relatives/carers?  YES  NO | | |
| Informed by (Print name): | | Date: |
| Who will be undertaking GT care on discharge? | Relationship to patient: | |
| Is training required? YES  NO  If YES, please identify those who require training  Training is undertaken by an outside agency  ‘ Homeward’ |  | |
| GDPR - please inform the patient/relative/cares that if they decided to proceed to have a gastrostomy placed, their details will be passed onto a third party homecare company (Homeward), who is responsible for training on home enteral feeding. Personal information will be securely used, stored and shared by the homecare company to make home deliveries of enteral feeding requirements.  Does the patient/relative/carer agree? YES  NO | | |
| GP/Nursing Home | Any problems associated with acceptance of patients with a Gastrostomy? YES  NO | | |

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| Signature:  Print name and designation:  Contact telephone number/bleep: | Date: |

**Please complete this form fully and email to** [**ComplexNutritionReferrals@nhslothian.scot.nhs.uk**](mailto:ComplexNutritionReferrals@nhslothian.scot.nhs.uk)

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| **For the Complex Nutrition Team’s Use Only** | |
| **GT is appropriate:**   * Referring team to request RIG/PEG via radiology on TRAK, then patient will be added to radiology list for RIG placement (Radiology will advise referring team of date of procedure) * Referring team to request PEG via endoscopy diagnostic procedure on TRAK, then patient will be triaged and added to the endoscopy list for a PEG placement (Endoscopy will advise the referring team of the date of procedure) | |
| **GT is not appropriate: -**  **Reason(s) for GT insertion not being appropriate (please tick all that apply)**  NG feeding not attempted  Severe untreated systemic disease e.g.pneumonia, stabilise patient before GT insertion  Uncontrolled coagulopathy  Severe neurological disease with risk of imminent deterioration/death  Severe respiratory disease (precluding sedation/endoscopy)  End stage dementia  Obstructive oropharyngeal tumours making endoscopy impossible  Intracerebral shunt (VP shunt)  Peritoneal dialysis  Ascites and liver disease with portal hypertension  Patient about to start eating  Consent issues  Poor prognosis  Family/Carer/relatives/GP/residential Nursing home disagreement  Other, please specify: | |
| **FOR GT Procedure** | **NOT FOR GT Procedure** |
| **Review after 1 week** | **Require further advice from Consultant** |