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| **Gastrostomy (GT) Multidisciplinary Assessment and Referral Form** |  Addressograph, orName      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.
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| **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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| HaematologyBiochemistry | 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 trainingTraining 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**

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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)
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| **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** |