

## ESSEX CHRONIC FATIGUE SYNDROME/ME SERVICE REFERRAL FORM

Please complete ALL sections of this referral form and fax to **01702 385 904**

<b>Patient Name &amp; Address:</b>	<b>GP Stamp/Address:</b>
<b>Postcode:</b>	<b>Date of Referral:</b>
<b>NHS No:</b>	<b>D.O.B:</b> (if patient aged 16 or 17 are they still registered at school/college?)
<b>Home Tel No:</b>	<b>Mobile No:</b>

### REFERRAL CRITERIA:

Patients accepted into the Essex CFS/ME LMDT need to fulfill the following criteria:

Please tick box if correct:

A primary complaint of unexplained fatigue

*This means that pain or other symptoms, if present are not the primary complaint, but may be an accompanying symptom.*

Duration of at least 4 months

BMI of less than 35

No clear alternative medical or psychiatric diagnosis has been made

The GP or referring doctor is willing to provide financially relevant reports

*E.g. for disability allowance, which will not be provided by LMDT staff.*

**CURRENT TREATMENTS:**

Medication	Other Treatments

**HISTORY:**

**CLINICAL FINDINGS:**

**Please attach current blood results (under three months old):**

<b>INVESTIGATIONS</b>
Haemoglobin
White cell count & differential
ESR or C-reactive protein
U & Es
LFTs
Calcium
Albumin
Creatine Kinase
TSH and free T4
Coeliac Screen
Fasting blood glucose
Paul Bunnell/Monospot (if appropriate age)
9am Cortisol
Urinalysis for blood, sugar & protein

Southend Hospital Patients ONLY  
Blood results can be obtained via ICE

Please tick box if available

**If you have any queries regarding this referral form, please contact the Service Manager, Noreen Buckley on 01702 43 55 55, ext 6696.**