FACIAL PALSY REFERRAL PROFORMA

Department of Health
An Roinn Sláinte
Männystrie O Poustie
www.health-ni.gov.uk

PATIENT DEMOGRAPHIC:		DO NOT WRITE IN THIS SECTION	
PATIENT SURNAME:	Click here to enter text.		METADATA
PATIENT FORENAME(S):	Click here to enter text.		
HSC NUMBER:	Click here to enter text.		
HOSPITAL NUMBER:	Click here to enter text.	Form Version:	V0.1
DATE OF BIRTH:	Click here to enter a date.	Version Owner:	FULL PRINTED NAME
		Original Template Location:	N:\EDM Project Management\bForms\Completed
		Date of PDG Approval:	DD/MM/YY Date of EDM Approval: DD/M/YY

Please complete the following proforma to allow us to ensure we see the patient in the appropriate facial palsy appointment. Thank you.

Diagnosis:	Click here to enter text.
Date of onset:	Click here to enter a date.
Side of facial palsy:	Left ☐ Right ☐ Bilateral ☐

Please now answer the following questions regarding the patients' facial palsy:

SYMPTOMS (Please choose the appropriate answer)		
1	Gradual onset facial palsy (over 3 weeks +)	Yes ☐ No ☐
2	No return of **any** facial function after 6 months	Yes ☐ No ☐
3	Incomplete facial palsy (including iatrogenic/trauma injuries), with sparing of certain parts of the face, that has not resolved within 2 months	Yes ☐ No ☐
4	Polycranial neuropathy (involvement of multiple cranial nerves such as double vision, reduced eye movement, unexplained hearing or balance loss, facial numbness, corneal numbness, swallowing issues, trismus) or other neurological deficits including seizures	Yes ☐ No ☐
5	Prolonged, severe ear or facial pain +/- ear discharge +/- history of bullseye rash (indicative of Lyme Disease)	Yes ☐ No ☐
6	Mass in the ear, parotid region or the neck	Yes ☐ No ☐
7	Associated skin cancer on the face in the region of the facial nerve	Yes ☐ No ☐
8	Recurrent episodes of facial palsy	Yes ☐ No ☐
9	Bilateral facial palsy	Yes ☐ No ☐
10	Significant unexplained weight loss (> 5kgs in the last 6 months)	Yes ☐ No ☐
11	Altered behaviour patterns	Yes ☐ No ☐
12	Severe psychosocial issues related to facial palsy (possibly including suicidal ideation)	Yes ☐ No ☐

Please add any additional information here:

Click here to enter text.

Name of referrer:	Click here to enter text.	**Designation:**	Click here to enter text.	**Signature:**	Click here to enter text.

CONTINENCE ASSESSMENT FORM

Queen Victoria Hospital
NHS Foundation Trust

PATIENT DEMOGRAPHIC:		DO NOT WRITE IN THIS SECTION			
PATIENT SURNAME:					METADATA
PATIENT FORENAME(S):					
NHS NUMBER:	AFFIX PATIENT ID				
HOSPITAL NUMBER:	LABEL HERE	Form Version:	V0.1		
DATE OF BIRTH:		Version Owner:	FULL PRINTED NAME		
		Original Template Location:	N:\EDM Project Management\bForms\Completed		
		Date of PDG Approval:	DD/MM/YY	Date of EDM Approval:	DD/M/YY

Please also attach the patients' medical history with your referral. Thank you