**Please refer via the Electronic Referral Service (eRS) - Rehabilitation, *'not otherwise specified’***

**Integrated Neighbourhood Offer:** For patients severely or very severely affected, the BCFS team may be able to work in partnership with the lead clinician/integrator host, local ME/CFS and/or community teams in an educational and advisory capacity to ensure care closer to home. Please contact the service to discuss further before referral.

|  |  |  |  |
| --- | --- | --- | --- |
| **PATIENT NAME, ADDRESS AND TELEPHONE NO.** | **DATE OF BIRTH** | **NHS NO.** | **CURRENT DIAGNOSES** |
|  |  |  |  |

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| --- |
| **Reason for referral:**  |

|  |
| --- |
| **GP Summary of relevant medical history and current treatments: (please complete or attach summaries/reports of relevant medical history)** |

**Please consider:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Clinical evidence for enduring fatigue **excluded.**(Please note that by making this referral it is assumed that all other potential pathologies have been excluded prior to making this referral. This referral cannot be made at the same time as any other pathology referrals). | **Yes** [ ] **No** [ ]  |  | Pain in several joints without swelling or redness | **Yes** [ ] **No** [ ]  |
|  | Headache of a new type, pattern, or severity. | **Yes** [ ] **No** [ ]  |
|  | Un-refreshing sleep | **Yes** [ ] **No** [ ]  |
| Neurological & cognitive problems – concentration/memory/information processing | **Yes** [ ] **No** [ ]  |  | Post-exertional malaise lasting 24 hours or more | **Yes** [ ] **No** [ ]  |
| Persistent sore throat | **Yes** [ ] **No** [ ]  |  | Autonomic nervous system problems – vasomotor/bowel or bladder dysfunction | **Yes** [ ] **No** [ ]  |
| Tender cervical or axillary lymph nodes | **Yes** [ ] **No** [ ]  |  | Neuroendocrine system dysfunction, e.g. loss of thermostasis, emotional lability | **Yes** [ ] **No** [ ]  |
| Muscle pain | **Yes** [ ] **No** [ ]  |  | Immune system dysfunction – recurrent infection, allergies, food intolerance | **Yes** [ ] **No** [ ]  |

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| **BMI Kg/m2** |  |
| STOP-Bang Score <http://www.stopbang.ca/osa/screening.php> **Score:** Score > 3 consider referral for respiratory sleep study before referral to BCFS |
| Has Obstructive Sleep Apnoea (OSA) been ruled out? **Yes** [ ]  **No** [ ]  |
| Relevant Family History |  |
| Mental health history**(If the patient has a mental health history, please attach reports and/or other relevant documentation)**  | **Current Diagnosis**(Please tick) | Date of Diagnosis | **Previous Diagnosis**  | From | To |
| None[ ] Depression [ ]  Psychosis [ ]  Bi-polar [ ] Anxiety[ ] Other:  |  | None[ ] Depression[ ]  Psychosis [ ]  Bi-polar [ ]  Anxiety[ ] Other:  |  |  |
| Current Mental Health worker name and contact details: |
| **Please attach print-out of current medication.** |
| **Patient’s current employment position:**[ ]  **Currently employed full-time** [ ]  **Currently employed part-time**[ ]  **Employment temporarily discontinued due to fatigue-related symptoms**[ ]  **Employment indefinitely discontinued due to fatigue-related symptoms**[ ]  **Other (please specify)** |

|  |
| --- |
| **Dates Bloods Completed (date/month/year): Between: \_\_/\_\_/\_\_ and \_\_/\_\_/\_\_** |
| * Full Blood Count (FBC)
 | * Thyroid Function: TSH, free T4
 |
| * Plasma Viscosity (PV) or ESR
 | * TTG
 |
| * C-Reactive Protein (CRP)
 | * Serum ferritin, B12, Folate
 |
| * Creatinine and electrolytes
 | * Urinalysis for blood, sugar, protein
 |
| * Liver function tests
 | * Virology/Serology (EBV, CMV, Hep B/C)
 |
| * Calcium and Phosphate
 | * Vitamin D
 |
| * Glucose (fasting or random)
 | * Autoimmune Profile
 |
| * Creatine Kinase (CK)
 | * Other antibody screening tests where appropriate (e.g. Lyme disease)
 |
| **NB NICE Guidance for management of Restless Leg Syndrome (RLS) recommends Serum Ferritin ≥ 75ng/mL** |

**IMPORTANT: Please do not send copies of blood results as they are not required and will not be read. Your referral is guarantee that *you are confirming* that the recommended blood tests have been conducted within the last 12 months and *you are satisfied* that the *results do not indicate* any other medically treatable cause for the patient’s enduring fatigue symptoms.**

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| --- | --- | --- |
|  **REFERRING GP’s NAME** | **SURGERY DETAILS**  | **DATE OF REFERRAL** |
|  |  |  |
| **GMC registration number.** |  |

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