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|  | Chronic Fatigue Syndrome/Fibromyalgia Service **St Bartholomew’s Hospital**  ***Website:*** [*http://bartscfs.eastlondon.nhs.uk*](http://bartscfs.eastlondon.nhs.uk) |

Please send this form to: Patricia Baker, CFS Clinic Coordinator CFS/Fibromyalgia Service,   
William Harvey House, 61 Bartholomew Close, St Bartholomew’s Hospital, LONDON EC1A 7BE,   
Tel: 0203 465 5974, Fax: 0203 465 6923

Or email [elt-tr.ChronicFatigue@nhs.net](mailto:elt-tr.chronicfatigue@nhs.net)|

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| **Patient Details** | | | |
| Patient Name | ………………………… | NHS Number | ………………………… |
| Name Address | ………………………………………………………………………………………. | | |
| DOB | ………………………… |  |  |
| Home Number | ………………………… | Mobile Number | ………………………… |
| Ethnicity | ………………………… |  |  |
| Interpreter required | Yes No | Language | ………………………… |

**Referral Criteria**

**Patient aged 18 and over**

**A provisional diagnosis of any of the following:**

1. Chronic Fatigue Syndrome
2. Fibromyalgia or chronic widespread pain
3. Fatigue secondary to a medical condition with optimised medical care

**Durations is at least 4 months**

**There is no alternative medical or psychiatric diagnosis explaining the symptoms:**

**There are copies of reports of normal range investigations, as described below:**

Full blood count

ESR or CRP

Urea and electrolytes

LFT’s

Calcium

Abumin

Creatine Kinase

Coeliac Screen

Thyroid function tests (Tw)

Radom Blood Glucose

Urinalysis for blood, sugar and

protein

**The GP is willing to continue to provide DWP reports (these reports will not be provided by the   
CFS service)**

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| **Referred by:** | | | |
| Dr Name | ………………………… | Designation | ………………………… |
| Practice Address | ………………………………………………………………………………………. | | |
| Date referral made | ………………………… |  |  |
| Telephone number | ………………………… | Fax Number | ………………………… |
| Email address | ………………………… |  |  |
| Please attach summary of medical history and relevant blood results to this form | | | |