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| **Description: InHealth Logo (Smaller).jpg** | **NHS logo**  |

**LOWER GI ENDOSCOPY REFERRAL FORM**

**Barking & Dagenham, Havering and Redbridge**

**Please note – we are unable to accept referrals for patients under 18 years of age**

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| **PATIENT** | **REFERRER** |
| NHS Number | NHS Number | Name | Registered GP |
| Forename | Forenames | GMC/HPC/NMC No |       |
| Surname | Surname | Address | Practice Address Stacked |
| Address | Patient Address Stacked |  |  |
| Date of Birth | DOB | Referring CCG Code |       |
| Telephone (Home) | Home Telephone       | Referring Practice Code |       |
| Telephone (Work) | Work Telephone       | Telephone No. (**for urgent clinical findings)** | Practice Main Telephone |
| Telephone (Mobile) | Mobile Telephone       | Fax No. |       |
| E-mail Address |       | NHS.net mail only |       |
| Gender | Sex | If interpreter required, language:       |
| Physical/Communication difficulties (specify if any):      | Wheelchair user? Yes [ ]  |
|  | The patient must be ambulant, or if a wheelchair user they must be able to transfer independently onto the examination couch. |
| Ethnicity: Ethnic Origin |  |
| **PRESENTING COMPLAINT & PROVISIONAL DIAGNOSIS**Please provide as much relevant clinical information as possible to ensure the most appropriate investigation is performed.      |
| PR Bleeding | [ ]  | Urgency | [ ]  | Other:       |
| Tenesmus | [ ]  | Constipation | [ ]  |  |
| Routine follow up | [ ]  | Altered bowel habit | [ ]  |  |
| Diarrhoea | [ ]  | Pain/Discomfort | [ ]  |  |
| **Please indicate which test you require:** **(we do not offer Gastroscopy)** |
| Flexible Sigmoidoscopy | [ ]  | Colonoscopy | [ ]  | Decision taken after pre-assessment | [ ]  | Date of referral System Date |
| Procedures related to the presenting symptoms and clinical findings may be performed/undertaken subject to informed consent. |
| The patient will receive bowel preparation (picolax, picolax and senna, klean-prep or moviprep).**I can confirm that this patient is fit to receive bowel preparation medication: (the patient cannot be booked unless this box is ticked) Yes** [ ]  |
| Is there any possibility of the patient being pregnant? | Yes [ ]  No [ ]  | Date of last period       /       /       |
| **Relevant Past Medical History (include previous & current treatment/medication where relevant)** |
| [ ]  | Family history of Bowel Cancer | Details:       |
| [ ]  | History of problems with sedation/anaesthesia | Details:       |
| [ ]  | Previous colonoscopy or sigmoidoscopy | Details:       |
| [ ]  | Previous abdominal surgery | Details:       |
| [ ]  | Diabetes | Medication:       |
| [ ]  | Anti-coagulation therapy | Medication:       |
| [ ]  | Hepatitis C | Details:       |
| [ ]  | Heart murmur or valve replacement | Details:       |
| [ ]  | Allergies | Details:       |
| **Please post, fax or e-mail this form to the InHealth Patient Referral Centre:****Sandbrook House, Sandbrook Way, Rochdale OL11 1RY****Tel: 0333 202 0297 Fax: 0333 200 1163 E-mail: inl.inhealthreferrals@nhs.net** | **www.inhealthgroup.com****Version: April 2014** |