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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**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **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** | |