Peterborough Community Endoscopy Service
6-10 Thistlemoor Road, New England, Peterborough PE1 3HP

Patient Referral Centre Contact Number: 0333 202 3187

Flexible Sigmoidoscopy - Referral Form

Patient Name	**GP Name**
Date of birth	Address
Address	
Tel No:	Postcode
Mobile:	Tel No
NHS Number	Fax Number
Date of Referral	

This procedure is not a replacement for the cancer 2 week referral system.

Urgent:	
Weight loss	
Rectal bleeding-recurrent over 4 weeks	
Bloody diarrhoea (mixed)	
Abdominal mass	
Soon:	
Consider colonoscopy if over 50yrs	
Change in bowel habit	
Persisting pain	
Rectal mucus loss	
Weight loss	
Routine:	
Erratic bowel habit/ mucus	
Pain and bloating	

Please note: Your patient will be prescribed **Citramag prior to their procedure**, by completing the referral you will be informing us that you deem the patient fit to take the medication

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Please complete the patient details on both pages of the referral form for clinical governance reasons. Thank you for your co-operation

Patient Name	
Date of birth	
Address	
Tel No:	
Mobile:	
NHS Number	
Date of Referral	

Medication:-	Other diseases:-	Previous Investigations:-

Diabetes	Yes	No	Anticoagulant Therapy	Yes	No

What to do now	This form should be emailed immediately to: inl.inhealthreferrals@nhs.net or faxed to **0333 200 1163.** Your patient will not be offered an appointment until the referral form is received.