NHS
WEST SUFFOLK

COMMUNITY ENDOSCOPY REFERRAL

Unit address – Thetford Living Centre, Croxton Road, Thetford, Norfolk, IP24 1JD
Telephone Number: 01842 767600 Fax Number: 01842 767624

Patient ID	**Referring Clinician**
Name: Date of birth: NHS number: Address: Post code: Telephone: Gender: Physical/communication difficulties (specify if any e.g poor vision/loss of hearing): If Interpreter required, language?	GP Name: Practice Address: Referring Practice Code: Urgent Telephone *: Fax *: ** for clinical enquiries use only* Date of Referral : Referrer's Signature:

PLEASE TICK BOX(ES)

Type of Scope required ☐ Upper ☐ Lower

Anaemia ☐ Yes ☐ No

Rectal Bleeding ☐ Yes ☐ No **If YES please tick relevant boxes:**

☐ Bright red ☐ Mixed with stool ☐ Pain ☐ No Pain

Anticoagulants ☐ Yes ☐ No **If YES, latest INR and date:**

Known Bowel Disease ☐ Yes ☐ No **If YES please state here:**

Unintentional Weight Loss ☐ Yes ☐ No **If YES please state here how much/duration:**

Dysphagia ☐ Yes ☐ No

Renal Disease ☐ Yes ☐ No

Respiratory Disease ☐ Yes ☐ No

Heart Disease ☐ Yes ☐ No

Diabetes Mellitus ☐ Yes ☐ No **If YES please State Treatment:**

Indications

Current Medication:

Allergies:

Infection Status:

Patient ID – Name: DOB: NHS No: