

## Community Lower GI Endoscopy Referral Form

**NB. Suspected cancer patients must be referred via the 2 week wait process**

SECTION 1: PATIENT DEMOGRAPHIC DETAILS			
First Names:		NHS Number:	
Last Name:		UBRN:	
Date of Birth		Gender:	
Address: (including postcode)			
Contact number:		Contact mobile:	
Email address:			
The patient needs an: <input type="checkbox"/> interpreter <span style="background-color: #cccccc; padding: 0 5px;"> </span> (specify language) <input type="checkbox"/> Lipspeaker <input type="checkbox"/> BSL interpreter			

SECTION 2: REFERRER INFORMATION			
Referrer name:		Contact number:	
Usual GP		Fax number:	
Practice Address:		Email address:	
Practice code:		Referral date:	

SECTION 3: CLINICAL DETAILS / SYMPTOMS	
<p><b>Flexible Sigmoidoscopy required</b></p> <p><b>Urgent:</b></p> <p><input type="checkbox"/> Weight loss</p> <p><input type="checkbox"/> Rectal bleeding – recurrent over 4 weeks but less than 6 weeks</p> <p><input type="checkbox"/> Bloody diarrhoea (mixed)</p> <p><b>Routine:</b></p> <p><input type="checkbox"/> Persistent diarrhoea without bleeding</p> <p><input type="checkbox"/> Erratic bowel habit/mucus</p> <p><input type="checkbox"/> Mucus discharge</p> <p><input type="checkbox"/> Persistent left sided abdominal pain</p> <p><input type="checkbox"/> Iron deficiency anaemia if fit and under 80 yrs old</p> <p><input type="checkbox"/> Change in bowel habit</p>	<p><b>Colonoscopy Required</b></p> <p><input type="checkbox"/> Unexplained chronic iron deficiency (please record SE FC, TIBC, and ferritin)</p> <p><b>Family History:</b></p> <p><input type="checkbox"/> One or more first degree relative who had colorectal cancer before 60 yrs of age</p> <p><input type="checkbox"/> Family history of HNPCC of polyposis coli</p> <p><input type="checkbox"/> History of colorectal cancer (follow up 5 yearly after 2 years)</p> <p><b>History of adenomas follow up:</b></p> <p><input type="checkbox"/> 5 yearly if 1-2 polyps &lt;1cm</p> <p><input type="checkbox"/> 3 yearly if 3-4 polyps &lt;1cm or 1 polyp &gt; 1cm</p> <p><input type="checkbox"/> 1 yearly if &gt;5 polyps &lt;1cm or 2 polyps &gt;1cm</p>

<p><b>Referral considerations:</b></p> <ul style="list-style-type: none"> <li>• Consider Colonoscopy if over 50 years</li> <li>• Consider flexible sigmoidoscopy for L sided symptoms (bright or flesh rectal bleeding, diarrhoea)</li> </ul>
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<p><b>Information for patients:</b></p> <ul style="list-style-type: none"> <li>• Colonoscopy is not without risk and patients should be informed that there is a 1:1000 risk of perforation, increasing to 1:500 during removal of caecal polyps. Patients usually receive pethidine, midazolam and often buscopan, during the procedure, and allergy or contra-indication to these medications should be checked.</li> </ul>
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**Clinical history (signs and symptoms):****Investigations undertaken (please give details)**

Please note that a CD/images will be required of any relevant imaging undertaken



**Does any of the following apply to your patient?**

Diabetic	<input type="checkbox"/> Y / N <input type="checkbox"/>	Major psychiatric disease	<input type="checkbox"/> Y / N <input type="checkbox"/>
Cardiac disease	<input type="checkbox"/> Y / N <input type="checkbox"/>	Major neurological disease	<input type="checkbox"/> Y / N <input type="checkbox"/>
Chronic respiratory disease	<input type="checkbox"/> Y / N <input type="checkbox"/>	Inability to sign consent form	<input type="checkbox"/> Y / N <input type="checkbox"/>
Taking anticoagulant medication	<input type="checkbox"/> Y / N <input type="checkbox"/>	Severe learning disabilities	<input type="checkbox"/> Y / N <input type="checkbox"/>
Language / hearing/ visual impairment	<input type="checkbox"/> Y / N <input type="checkbox"/>		
Allergies	<input type="checkbox"/> Y / N <input type="checkbox"/>	If yes, what:	
Does the patient present a communicable infection risk? <input type="checkbox"/> Y / N <input type="checkbox"/>			
Has the patient ever had the following?			
MRSA	<input type="checkbox"/> Y / N <input type="checkbox"/>		
Clostridium	<input type="checkbox"/> Y / N <input type="checkbox"/>		
Has the patient been an NHS inpatient in the last 6 months? <input type="checkbox"/> Y / N <input type="checkbox"/>			

**SECTION 4: EXCLUSION CRITERIA**

- Under 18 years of age
- Sleep apnoea
- Patients over 220kg weight
- Patients with BMI over 40
- ASA unstable 3, 4 or 5

**Please Fax to the preferred community provider**

<input type="checkbox"/>	 St Nicholas Endoscopy Service (Dersingham)	Fax number:	01553 692181
<input type="checkbox"/>	 Prime Diagnostics (Thetford Healthy Living Centre)	Fax number	01842 767624