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| --- | --- |
| **Patient ID**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? | **Referring Clinician**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****Anaemia****Rectal Bleeding** **Anticoagulants** **Known Bowel Disease****Unintentional Weight Loss****Dysphagia****Renal Disease** **Respiratory Disease****Heart Disease****Diabetes Mellitus****Indications** | [ ]  Upper [ ]  Lower[ ]  Yes [ ]  No[ ]  Yes [ ]  No **If YES please tick relevant boxes:** [ ]  Bright red [ ]  Mixed with stool [ ]  Pain [ ]  No Pain[ ]  Yes [ ]  No **If YES, latest INR and date:**[ ]  Yes [ ]  No **If YES please state here:** [ ]  Yes [ ]  No **If YES please state here how much/duration:**[ ]  Yes [ ]  No[ ]  Yes [ ]  No[ ]  Yes [ ]  No[ ]  Yes [ ]  No[ ]  Yes [ ]  No **If YES please State Treatment:**  |
| **Current Medication:****Allergies:** **Infection Status:****Patient ID – Name:**   **DOB:**   **NHS No:**  |