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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:** | | |