

ENDOSCOPY REQUEST FORM

PLEASE NOTE - WE ARE UNABLE TO ACCEPT REFERRALS FOR PATIENTS UNDER 18 YEARS OF AGE

<p>Patient ID</p> <p>NHS Number _____</p> <p>First Name _____</p> <p>Surname _____</p> <p>Address _____</p> <p>_____</p> <p>_____ Post Code _____</p> <p>Date of Birth _____</p> <p>Telephone (Home) _____</p> <p>Telephone (Work) _____</p> <p>Telephone (Mobile) _____</p> <p>Email Address _____</p> <p>Gender Male <input type="checkbox"/> Female <input type="checkbox"/></p>	<p>Referring Clinician</p> <p>Name _____</p> <p>GMC/HPC/NMC No. _____</p> <p>Address _____</p> <p>_____</p> <p>_____ Post Code _____</p> <p>Referring PCT Code _____</p> <p>Referring Practice Code _____</p> <p>Telephone No. (For urgent clinical findings) _____</p> <p>Fax No. _____</p> <p>NHS Mail (nhs.net only) _____</p>																		
<p>Physical/Communication difficulties (Specify if any) _____</p> <p>_____</p> <p>If interpreter required, language _____</p> <p>Religion _____</p> <p>Ethnicity _____</p>	<p>Eligible for NHS Funded Transport Yes <input type="checkbox"/></p> <p>Car Transport Required Yes <input type="checkbox"/></p> <p>Wheelchair User Yes <input type="checkbox"/></p> <p>The patient must be ambulant, or if a wheelchair user they must be able to transfer independently on to the scanner or examination couch.</p>																		
<p>Clinical Indication/Problem</p> <p>Please provide as much relevant clinical information to ensure the most appropriate investigation is performed.</p> <table style="width:100%;"> <tr> <td><input type="checkbox"/> PR bleeding</td> <td><input type="checkbox"/> Urgency</td> <td>Other: _____</td> </tr> <tr> <td><input type="checkbox"/> Tenesmus</td> <td><input type="checkbox"/> Constipation</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> Routine follow up</td> <td><input type="checkbox"/> Altered bowel habit</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> Diarrhoea</td> <td><input type="checkbox"/> Pain/Discomfort</td> <td>_____</td> </tr> </table> <p>Procedures related to the presenting symptoms and clinical findings may be performed/undertaken subject to informed consent being given by the patient.</p>		<input type="checkbox"/> PR bleeding	<input type="checkbox"/> Urgency	Other: _____	<input type="checkbox"/> Tenesmus	<input type="checkbox"/> Constipation	_____	<input type="checkbox"/> Routine follow up	<input type="checkbox"/> Altered bowel habit	_____	<input type="checkbox"/> Diarrhoea	<input type="checkbox"/> Pain/Discomfort	_____						
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<p>Please indicate which test you require to be carried out:</p> <p><input type="checkbox"/> Flexible Sigmoidoscopy <input type="checkbox"/> Colonoscopy <input type="checkbox"/> Decision taken after pre-assessment</p>																			
<p>Relevant Past Medical History (include previous & current treatment/medication where relevant)</p> <table style="width:100%;"> <tr> <td><input type="checkbox"/> Family history of Bowel Cancer</td> <td>Details: _____</td> </tr> <tr> <td><input type="checkbox"/> History of problems with sedation/anaesthesia</td> <td>Details: _____</td> </tr> <tr> <td><input type="checkbox"/> Previous colonoscopy or sigmoidoscopy</td> <td>Details: _____</td> </tr> <tr> <td><input type="checkbox"/> Previous abdominal surgery</td> <td>Details: _____</td> </tr> <tr> <td><input type="checkbox"/> Diabetes</td> <td>Medication: _____</td> </tr> <tr> <td><input type="checkbox"/> Anti-coagulation therapy</td> <td>Medication: _____</td> </tr> <tr> <td><input type="checkbox"/> Hepatitis C</td> <td>Details: _____</td> </tr> <tr> <td><input type="checkbox"/> Heart murmur or valve replacement</td> <td>Details: _____</td> </tr> <tr> <td><input type="checkbox"/> Allergies</td> <td>Details: _____</td> </tr> </table> <p>The patient will receive bowel preparation (picolax, picolax and senna or picolax and klean-prep). I can confirm that this patient is fit to receive bowel preparation medication: (the patient cannot be booked unless the yes box is ticked) <input type="checkbox"/> Yes</p>		<input type="checkbox"/> Family history of Bowel Cancer	Details: _____	<input type="checkbox"/> History of problems with sedation/anaesthesia	Details: _____	<input type="checkbox"/> Previous colonoscopy or sigmoidoscopy	Details: _____	<input type="checkbox"/> Previous abdominal surgery	Details: _____	<input type="checkbox"/> Diabetes	Medication: _____	<input type="checkbox"/> Anti-coagulation therapy	Medication: _____	<input type="checkbox"/> Hepatitis C	Details: _____	<input type="checkbox"/> Heart murmur or valve replacement	Details: _____	<input type="checkbox"/> Allergies	Details: _____
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<p>Is there any possibility of the patient being pregnant? Yes <input type="checkbox"/> No <input type="checkbox"/> Date of last menstrual period ___/___/_____</p>																			
<p>Referrer's Signature Date of request ___/___/_____</p>																			