**Private Endoscopy Referral Form**

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| Date of referral |  |
| **Suitability Criteria** |
| **Please confirm your patient is appropriate for the service** |
| The referral will be rejected if these are not ticked🞏 18 or over🞏 able to give informed consent🞏 able to get onto a trolley and roll unaided onto their side and back for the procedure 🞏 is under 220kg 🞏 CKD4 or under🞏 is fit to receive bowel preparation medication (moviprep/citramag and senna) – *lower procedures only* |
| Physical/Communication difficulties (specify if any) |  |
| If interpreter is required, specify language |  |
| Wheelchair user 🞏 Yes 🞏 No | Is the patient pregnant 🞏 Yes 🞏 No  |
| **PATIENT** | **REFERRER** |
| NHS Number |  | Name |  |
| Forename |  | GMC/HPC/NMC No |  |
| Surname |  | Address |
| Address |  |
| Date of Birth |  | Referring CCG Code |  |
| Telephone (Home) |  | Referring Practice Code |  |
| Telephone (Work) |  | Telephone No.(for urgent clinical findings) |  |
| Telephone (Mobile) |  | Fax No |  |
| E-mail address |  | NHS.net mail address |  |
| Ethnicity | Gender 🞏 Male 🞏 Female |  |  |

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| **LOWER INDICATIONS** | **UPPER INDICATIONS** |
| Abdominal PainPlease indicate: Left hand side🞏 Right hand side 🞏 | 🞏 | Barretts Oesophagus Surveillance |  🞏 |
| Altered bowel habit | 🞏 | Bloating |  🞏 |
| Bloating | 🞏 | Coeliac Disease for diagnostic biopsy | 🞏 |
| Chronic diarrhoea | 🞏 | Dyspepsia (persistent or worsening) |  🞏 |
| Constipation | 🞏 | Dysphagia |  🞏 |
| Rectal bleeding 🞏 Bright red 🞏 Mixed with stool | 🞏 | Reflux symptoms unresponsive to lifestyle changes, PPI, H2RA or prokinetic agents |  🞏 |
| Urgency/Tenesmus | 🞏 | Resistant H.Pylori infection and/or worsening dyspepsia in spite of appropriate treatment |  🞏 |
| Unexplained weight lossPlease indicate over what period : |  🞏 |
| Iron Deficient AnaemiaPlease provide: FBC, Fe, Ferritin, TTg/EMA resultsAlso consider Colonoscopy |  🞏 |
| **Please provide as much relevant clinical information below:** |
| Flexible Sigmoidoscopy | [ ]  | Colonoscopy | [ ]  | Gastroscopy | [ ]  | Capsule Endoscopy | [ ]  | Banding of Haemorrhoids | [ ]  |
| Complex OGD | [ ]  | Complex Colonoscopy  | [ ]  | Decision to be made after pre-assessment (lowers only) | [ ]  |
| Procedures related to the presenting symptoms and clinical findings may be performed/undertaken subject to informed consent.  |
| **Relevant Past Medical History (include previous & current treatment/medication where relevant)** |
| [ ]  | Family history of Bowel or Upper GI Cancer | Details:      |
| [ ]  | Previous Endoscopy | Details:      |
| [ ]  | Previous abdominal surgery | Details:      |
| [ ]  | Diabetes | Medication:      |
| [ ]  | Anti-coagulation therapy | Medication:      |
| [ ]  | Pacemaker (Yes or No) Please Indicate | Details:      |
| **When completed please email this form to booking@vista-health.co.uk or fax it to 0333 200 2065** | [**www.vista-health.co.uk**](http://www.vista-health.co.uk)**April 2021** |