**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 Pain  Please 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 loss  Please indicate over what period : | | | | | | | | | | | | | | | 🞏 |
| Iron Deficient Anaemia  Please provide: FBC, Fe, Ferritin, TTg/EMA results  Also 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** | | | | | |