UKSH

NHS

ROUTINE GASTROSCOPY REFERRAL FORM

Please mark an X to indicate which treatment centre you are referring your patient to and fax this completed and signed form to the number indicated below:

	Emersons Green NHS Treatment Centre **(fax. 0117 906 1950)**		Devizes NHS Treatment Centre **(fax. 0117 906 1950)**

Date of Referral:		**Referring PCT:**	

Patient Details	
Full name	
Date of birth	
NHS No.	
Address	
Postcode	
Home Tel.	
Work Tel.	

Referrer Details	
Referring GP	
Practice name	
Practice Address	
Postcode	
Telephone	
Fax	
Email address	

Note: This service is <u>not</u> for suspected cancer referrals – Please refer to local DGH

INDICATION (please use **X**)

	Dyspepsia >50 yrs of age
	Iron deficiency anaemia
	Melaena (if within 7 days -> refer for acute hospital care)
	Persistent nausea and/or vomiting
	Unintended weight loss
	Family history of gastric or oesophageal cancer (more than two 1st degree relatives)
	Gastro oesophageal reflux disease (persisting despite appropriate treatment)
	Surveillance of Barrett's oesophagitis (please give previous surveillance history)
	Painful or difficulty swallowing (dysphagia)
	Confirmation of suspected coeliac disease by D2 biopsies

NB. patient must remain on gluten containing diet before biopsy for a minimum of two weeks

Relevant history and recent management

BP		Date		Weight (KG)		BMI	

Past relevant medical and surgical history

Referral requirements for day case procedure

- Escorted home following procedure
- Accompanied at home for 24 hrs following procedure
- Access to telephone at home

Other information required

Allergies? Please state	
Regular medication? Please state or attach list	

If you have any questions about your referral please call **0117 906 1822** and the lead endoscopist will return your call as soon as possible

Please note: If an entry is left blank on this form a negative answer will be assumed.

Form issued: August 2010