

DIRECT ACCESS ENDOSCOPY REFERRAL FORM

Please fax this form to 020 7881 4099
 Secretary, Endoscopy Unit, telephone: 020 7881 4098

PATIENT NAME: _____ **HOME TEL:** _____
ADDRESS: _____ **MOBILE:** _____
 _____ **WORK TEL:** _____
 _____ **DATE OF BIRTH:** _____

REFERRING CLINICIAN DETAILS:

NAME: _____ **TEL:** _____
ADDRESS: _____ **FAX:** _____
 _____ **EMAIL:** _____

INVESTIGATIONS REQUIRED (PLEASE TICK):

INVESTIGATION	URGENT	NON-URGENT
Flexible Sigmoidoscopy		
Upper G.I. / Endoscopy		
Colonoscopy		

INDICATIONS FOR TEST: _____

PATIENT GENERAL HEALTH:

DOES THE PATIENT HAVE:	Y	N		Y	N
Ischaemic Heart Disease			Valvular Heart Disease		
Diabetes			Respiratory Disease		
Is this Patient immunocompromised?					
Is this Patient taking warfarin, clopidogrel or aspirin? (delete as appropriate)					

CURRENT MEDICATION: _____

DRUG ALLERGIES: _____

PREVIOUS SERIOUS ILLNESSES: (please list with approximate dates where possible)