LOWER GI ENDOSCOPY REFERRAL FORM

Please note – we are unable to accept referrals for patients under 18 years of age

Please indicate which test you require, by ticking the box to the right of the correct procedure:

FLEXIBLE SIGMOIDOSCOPY ☐	**COLONOSCOPY** ☐

PATIENT INFORMATION

Patient's Name:	Booking priority:
NHS number:	Is patient able to give consent?
Patient Address:	Communication difficulties (specify if any):
Gender:	Translation required?
Date of birth:	Language:
Home Telephone:	Transport required?
Mobile Telephone:	Wheelchair user?
Email Address:	

REFERRER DETAILS

Referring GP:	GP Address:
Telephone:	
Fax:	Referring Practice Code:
NHS Email:	Referring CCG:

Please email or fax this form to the NHS Services Team:
Email: highgatecontracts.referral@nhs.net
Fax: 020 8347 3873 Tel.: 020 8347 3856
Highgate Private Hospital, 17-19 View Road, Highgate, N6 4DJ

INDICATIONS					
	YES	**NO**		**YES**	**NO**
PR bleeding			Dysphagia		
Altered bowel habit			Tenesmus		
Diarrhoea			Pain/Discomfort		
Constipation			Iron deficiency		
Weight Loss					
Other:					

MEDICATION					
	YES	**NO**		**YES**	**NO**
Aspirin			Warfarin		
Clopidogrel			Iron Tablets		
Other:					

MEDICAL HISTORY (please provide full details below)					
	YES	**NO**		**YES**	**NO**
Heart disease			Alcohol misuse		
Liver disease			Diabetes (Type 1)		
Hypertension			Diabetes (Type 2)		
Asthma			Haemophillia		
COPD			Haematemesis/Melaena		
vCJD or CJD History/known risk (Notification from Public Health England/Family Hx or prion disease/growth hormone or gonadotrophin/brain or spinal cord surgery)					
Other:					

BOWEL PREPARATION FOR COLONOSCOPY	**YES**	**NO**
Bowel preparation needs to be prescribed for each Colonoscopy (picolax, picolax and senna, klean-prep or moviprep). **I can confirm that this patient is fit to receive bowel preparation medication.** (the Patient cannot be booked unless the 'yes' box is ticked)		

PLEASE PROVIDE FULL CLINICAL DETAILS: