

Hermon Taylor Endoscopy Unit, Basement, Alex Wing, RLH.

ENDOSCOPY REQUEST: fax to 020 7375 0613 Tel ext 7218, 3834 or 2807

REQUESTS MUST BE SIGNED BY THE REFERRING DOCTOR

Poorly completed forms may be returned.

Use special forms for PEGs.

<p>1. Procedure(s)</p> <p><input type="checkbox"/> Gastroscopy</p> <p><input type="checkbox"/> Colonoscopy</p> <p><input type="checkbox"/> Flexi-sigmoidoscopy</p> <p><input type="checkbox"/> ERCP **</p> <p><input type="checkbox"/> EUS **</p> <p>Other (specify)</p> <p><i>**Gastroenterologist must be consulted</i></p>	<p>2. Referral type</p> <p><input type="checkbox"/> Outpatient</p> <p><input type="checkbox"/> In-patient: location</p> <p><input type="checkbox"/> Planned follow up examination</p> <p>Date due -</p>
<p>3. Patient name Date of birth</p> <p>Address</p> <p>Registry number</p> <p>How can we contact the patient? (essential)</p> <p><input type="checkbox"/> Home or Work</p> <p>or Mobile or e-mail</p> <ul style="list-style-type: none"> • Dates when patient not available..... • Transport essential? Yes/No • <i>Patient reminded to bring escort if sedation planned, & interpreter if needed</i> <p>Consultant (NAME essential) Department Phone</p>	
<div style="border: 1px solid black; padding: 5px; margin: 5px auto; width: fit-content;"> <p>Date of request (essential)</p> <p><input type="checkbox"/> ROUTINE</p> <p><input type="checkbox"/> URGENT see over page</p> <p><input type="checkbox"/> EMERGENCY</p> </div>	
<p>4. History/Indication/Surgery/Suspected diagnosis (essential)</p> <p>Test results: Hb MCV INR Platelet count</p> <p> Bilirubin ALT ALP</p> <p>Ultrasound/CT (essential for ERCP):</p>	
<p>5. Other relevant problems (essential)</p> <p><input type="checkbox"/> Transmissible infection</p> <p><input type="checkbox"/> Heart valve disease/prosthesis</p> <p><input type="checkbox"/> Coronary disease/ COPD</p> <p><input type="checkbox"/> Drug allergy</p> <p><input type="checkbox"/> Pacemaker</p> <p><input type="checkbox"/> Anticoagulants for.....</p> <p><input type="checkbox"/> IDDM/NIDDM</p>	<p>List current medications</p> <p><input type="checkbox"/> NSAIDs</p> <p><input type="checkbox"/> Warfarin</p> <p><input type="checkbox"/> Insulin</p> <p><input type="checkbox"/> Oral hypoglycaemics</p> <p><input type="checkbox"/> Steroids</p> <p><input type="checkbox"/> Other</p>
<p>REFERRER'S SIGNATURE*: NAME: BLEEP/PHONE</p>	
<p>* ESSENTIAL FOR ALL CASES, & USED FOR PRESCRIPTION OF BOWEL PREPARATION FOR COLONOSCOPY SEE OVER</p>	
<p style="text-align: center;">ENDOSCOPY UNIT USE ONLY</p> <p>Date validated: Validator: Appointment date:</p>	

Bowel preparation for colonoscopy:

By signing this request from you are certifying that, in your opinion, the patient is fit to have the bowel preparation for this test. The form will be used as the prescription for the laxatives.

The bowel preparation consists of dietary restriction, stopping oral iron a week before the procedure, and oral bisacodyl and Picolax laxatives. Further details are available from the Endoscopy Unit.

URGENT REFERRALS FOR SUSPECTED GI CANCER

Adapted from the NHS Executive's *Referral Guidelines for Suspected Cancer*
(London: Department of Health, 2000)

The criteria on this form are less stringent than the National Guidelines.

NB INAPPROPRIATE URGENT REFERRALS SLOW THE PROCESS FOR ALL PATIENTS

LOWER	UPPER
<ul style="list-style-type: none"> • Definite, palpable, rectal (not pelvic) mass • Rectal bleeding with change in bowel habit to more frequent defecation or looser stools (or both), <i>persistent over six weeks</i> • Iron deficiency anaemia (haemoglobin concentration <11.0 g/dl in men or <10.0 g/dl in postmenopausal women, with MCV <80 <u>and</u> low ferritin) without other obvious cause • Right sided abdominal mass with ultrasound compatible with colonic origin <p>Age over 60 years</p> <ul style="list-style-type: none"> • Rectal bleeding persistently without anal symptoms (soreness, discomfort, itching, lumps, prolapse, or pain) • Change of bowel habit to more frequent defecation or looser stools (or both), without rectal bleeding, and persistent for six weeks • Consider CT as the primary investigation in the frail elderly <p>NB <i>Patients with the following symptoms and no abdominal or rectal mass are only at average (population or background) risk of colorectal cancer:</i></p> <ul style="list-style-type: none"> • <i>Rectal bleeding with perianal symptoms (see above)</i> • <i>Change in bowel habit to decreased frequency of defecation and harder stools</i> • <i>Abdominal pain without clear evidence of intestinal obstruction</i> <p>If you suspect rectal cancer you must do a rectal examination before referral</p>	<ul style="list-style-type: none"> • Dysphagia – food or fluid sticking on swallowing • Dyspepsia with ‘alarm’ symptoms: weight loss, proven anaemia, or persistent vomiting • Iron deficiency anaemia (haemoglobin concentration <11.0 g/dl in men or <10.0 g/dl in postmenopausal women, with MCV <80 and low ferritin) without obvious cause • Age 55 years or more with onset of dyspepsia less than one year ago and <ul style="list-style-type: none"> - Family history of upper GI cancer in >2 first degree relatives - Barrett’s oesophagus - Pernicious anaemia - Peptic ulcer surgery over 20 years ago - Known dysplasia, atrophic gastritis, intestinal metaplasia <p>PPIs and H2RBs should <i>ideally</i> be stopped 4 weeks before endoscopy for dyspepsia (PPIs may mask ulcers & oesophagitis; make testing for Hp difficult; & [rarely] may impede diagnosis of early gastric cancer)</p> <ul style="list-style-type: none"> • Jaundice – especially painless jaundice in the over 40’s • Upper abdominal mass – ultrasound may be the best initial test • Weight loss – CT or ultrasound may be the best initial test