SEE AND TREAT GASTROSCOPY REQUEST FORM (NHS)



Patient detai	ils
Surname	
Forename	
Male/Female	
Address	
Postcode	
Date of birth	
Daytime Contact No	
Mobile Number	
NHS NUMBER	

GP details	
Name	
Surgery	
Tel Number	
GP Signature	
Referral date	

Expected Diagnosis (please tick one or more boxes)

	Oesophageal Cancer			Duodenal Ulcer				
	Gastric Cancer			Gastric Ulcer				
	Oesophageal Stricture			Oesophagitis				
			GOR/Hiatus Hernia					
Symptoms (please tick one or more boxes)								
Epigastric Pain Weig		Weight Loss		Dysphagia				
		Nausea/Vomiting			Distension/Bloating			
		Duration of			Have these symptoms occurred			
ain		Symptoms			before?			
Current Medication/Treatment (please list below)								
Is patient on treatment? Yes / No		Specif	Specify: H2 antagonists/proton pump inhibitor					
Is patient on NSAID?		Yes / No	Other (please specify)					
Is patient on Aspirin? Yes / No								
Other problems (please tick box and note any other relevant clinical indications)								
			Other:					
Alco	hol							
Tobacco per day		Alcohol units per week						
Other Information								
History of gastric surgery			Results of investigations					
Body Mass Index:			Please indicate the site of your patient's abdominal pain:					
					0			
	ain licatio reatm ISAID Spirin ems (p Alco ay nation tric su	Oes Olease tick o Displace tic	Oesophag	Oesophageal Stricture olease tick one or more boxes) Nauseal Vomiting Duration of symptoms ication/Treatment (please list reatment? Yes / No ISAID? Yes / No spirin? Yes / No spirin? Yes / No mation Other: ay It is surgery	Oesophageal Stricture Dlease tick one or more boxes) Nausea/Vomiting Nausea/Vomiting Duration of Symptoms ication/Treatment (please list below) reatment? Yes / No ISAID? Yes / No Spirin? Yes / No Spirin? Yes / No Small (please tick box and note any oth Other: Other: Alcohol ay Alcohol httics Res	Oesophageal Stricture Oesophagitis GOR/Hiatus Hernia Dease tick one or more boxes) Oesophagia Nausea/Vomiting Distension/Bloating Duration of Have these sympto before? Duration of ication/Treatment (please list below) Specify: H2 antagonists/pro reatment? Yes / No ISAID? Yes / No Symptoms Other (please specify) Spirin? Yes / No Sems (please tick box and note any other relevant clinical Other: Other: ay Alcohol ay Alcohol units per week nation Results of investigations tric surgery Please indicate the site patient's abdominal pai		

Are you happy for your patient to be followed up automatically as a result of the Endoscopy: Yes / No

<u>Please email this form to rhc.ashteadnhsoutpatients@nhs.net</u>

Alternatively post to Ashtead Hospital, NHS Department, The Warren, Ashtead, KT21 2SB

(Tel: 01372 221421)