Oaks Hospital
Part of Ramsay Health Care

Referral Form for 'Low Risk' Category Patients
Direct Access Diagnostic Upper GI Endoscopy Service

Important: The patient remains the clinical responsibility of the referring GP at all times. In the event that either during the procedure or histology result indicates the presence of cancer, then a Consultant will undertake referral of the patient directly into the Cancer MDT/pathway. However, the GP is responsible for remaining pro-actively involved in tracking the referral, diagnostic outcomes and appropriate treatment of the patient.

To make a referral to this service please complete this form fully, appending any other relevant information and then attach this form to either (1) the E-RS chosen appointment; or (2) secure NHS Mail to RHC.Oaks@nhs.net

Section 1 – Referral Status				
In making this referral I am confirming that:- ***i. This meets the criteria for referral into this service (as per the current published pathway)*** ***ii. I have discussed the nature of this procedure with the patient*** ***iii. The patient has confirmed their understanding of and their willingness to undergo the endoscopy*** ***iv. The appropriate WHO 'Patient Performance Status' (indicate as appropriate in one of the following):***				
0 *= Fully active, able to carry on all pre-disease performance without restriction;*	***1*** *= Restricted in physically strenuous activity but ambulatory and able to carry out light/sedentary work, e.g. house or office work;*	***2*** *= Ambulatory and capable of self-care, but unable to carry out work activities. Up and active > 50% of waking hours;*	***3*** *=Capable of only limited self-care. Confined to bed or chair >50% of waking hours;*	***4*** *=Completely disabled. Cannot carry out any self-care. Totally confined to bed or chair.*

Patient Seen Date:	
Referral Made Date:	

Have you been advised by either Consultant Connect or otherwise directed by a GI Consultant to refer the patient via this service?	**Yes / No**

Section 2 – Patient Details		
Name:	**Address**	
Date of Birth		
Gender **Age:**		
NHS Number	**Tel No**	

Section 3 – GP Practice Details		
GP Name:	**Address**	
Tel No		
Practice Name		
Secure NHS Mail Address		

Section 4 - Clinical information ***(Please indicate everything that applies to this patient and include any relevant further information as appropriate)***		
Symptoms prompting referral:	**Yes / No**	**Any additional detail:**
Dyspepsia		
Nausea/Vomiting		
Upper abdominal pain		
Unexplained Anaemia		***If yes, the blood test results must be recorded /appended here:***

If the patient is aged 55+ then please indicate if they have:		
	Yes / No	**Any additional detail:**
A raised platelet count		***If yes, the blood test results must be recorded /appended here:***

If yes state if they also have any /some /all of the following:-		
	Yes /No	**Any additional detail:**
Nausea		
Vomiting		
Weight loss		
Reflux		
Dyspepsia		
Upper abdominal pain		

H pylori tested?	**Yes / No**	**Test Date**	**Please state the test result**	**Treated? Yes / No**

State the BMI of the patient at referral:		
	Yes / No	**If yes please indicate control method applicable and any additional detail:**
Diabetic Patient?		
Insulin ?		

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Tablets ?		
Diet alone ?		

Patient on Anti-platelet Therapy? *(e.g. non-aspirin; Clopidogrel; Ticagrelor; Prasugrel):* *If yes, the guidance for patients pre procedure is to* ***continue their medication as normal***	**Yes / No**
Patient on Warfarin? *If yes, the guidance for patients pre procedure is to* ***continue the medication as normal but please check the that INR is in the therapeutic range within 5 days of the procedure due date***	
Patient on NOAC? *(e.g. Rivaroxaban; Apixaban; Pixaban; Dabigatran; Edoxaban): If yes, the guidance for patients pre procedure is to* ***omit on the day of the procedure only***	

Section 5 - Past Medical History

Section 6 – Details of Patient Medications / Relevant Additional Information