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**IRON DEFICIENCY ANAEMIA Guidance and referral form**

For referral to the Royal Hampshire County Hospital IDA clinic

**Send to fax 01962825196**

**From November 2017 refer on e-referrals service**

If the patient has blood loss or symptoms of gastro-intestinal disease investigate as appropriate to their presentation (this clinic is not appropriate).

|  |  |
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| **Patient Details** | **GP Practice Details** |
| **Name:** | **Surgery:** |
| **Address:** | **Surgery address:** |
| **Phone:** | **Surgery Phone:** |
| **NHS Number:** | **Referrer:** |

The IDA clinic is for asymptomatic patients with iron deficiency as confirmed below:

Male: Hb <130g/L and/or ferritin <30

Female (without menorrhagia): Hb <120g/L and/or ferritin <30

Please ensure the following tests have been sent:

FBC

Ferritin  **(**before starting on oral iron)

eGFR

tTG

Urine dipstick (for haematuria

**Is patient fit for bowel prep?**

*The NPSA requires that as the requesting physician you:*

1. Are satisfied that there are no contraindications to or risks from bowel prep in this patient Y / N

2. Are satisfied the patient will understand the instructions for the bowel prep Y / N

Age >80 yrs Y / N

Myocardial infarction within the last 6 weeks Y / N  Diabetic on Insulin Y / N

Unstable Angina Y / N  Diabetic on oral medication Y / N

CVA within the last 6 weeks Y / N

Uncontrolled cardiac failure Y / N  Is patient on anticoagulant/ antiplatelet agent Y / N

Respiratory impairment limiting activity Y / N  If so, why:

Significant renal impairment (eGFR <30 ) Y / N  Atrial fibrillation Y / N

Malignancy Y / N  Venous thromboembolism Y / N

Significant limitation to mobility Y / N  Metallic heart valve Y / N

***If yes to any of the above, the patient may only have Gastroscopy initially, followed by further assessment.***

**Significant medical history**

(Please give details of any Yes above)

**Problems**

***Active***

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| --- | --- | --- | --- |
| **Date** | **Problem** | **Associated Text** | **Date Ended** |
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***Significant Past***

|  |  |  |  |
| --- | --- | --- | --- |
| **Date** | **Problem** | **Associated Text** | **Date Ended** |
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**Allergies**

No allergies recorded.

**List current medication**:

**Medication**

***Acute***

|  |  |  |  |
| --- | --- | --- | --- |
| **Drug** | **Dosage** | **Quantity** | **Last Issued On** |
|  |  |  |  |

Date Signed

*The patient will be sent an appointment for the iron deficiency anaemia clinic within two weeks. Following triage they may be sent straight to endoscopy. Please provide a telephone number that can be used to contact the patient within the next few days. Incomplete forms or those where the criteria are not fulfilled will be returned.*