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| **UPPER GI ENDOSCOPY REQUEST FORM** |  |

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| **Patient Details:** |  |
| Hospital no. |  | NHS no. |  |
| Surname |  | Forenames |  |
| Previous surname |  | Title |  |
| Date of Birth |  | Sex |  |
| AddressPost code |  | Home tel. no. |  |
| Work tel. no. |  |
| Mobile tel.no. |  |

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| --- | --- | --- | --- |
| Referring clinician |  | Preferred clinician (if applicable) |  |
| G.P practice |  | [ ]  New referral? [ ]  Re-referral? |
| Date of referral |  | Dates patient not available |  |
| Date of consultation |  |

 **Communication and Accessibilty needs:**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Interpreter required?: | Yes | [ ]  | No | [ ]  | Wheelchair access required?  | Yes | [ ]  | No | [ ]  |
| Language:  |       | Learning Disability:  |       |
| Hearing: |       | Other disability needing consideration:  |       |
| Vision: |       |

**Medical History**

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| --- | --- |
| Weight:  |  |
| Anticoagulation  | [ ]  | Yes |  [ ]  | No  | Reason: |  |
| [ ]  | Warfarin | [ ]  | Apixiban | [ ]  | Rivaroxaban | [ ]  | Edoxaban | [ ]  | Other, please state: |  |
| INR: |  | Date: |  | U&Es  |  | Date: |  |
| Diabetes  | [ ]  | IDDM | [ ]  | NIDDM  | [ ]  | Diet controlled | [ ]   | Epilepsy |
| [ ]   | Ischaemic heart disease | [ ]   | Dementia  | [ ]  | Consent 4 required |
| [ ]   | Respiratory compromised | [ ]   | Learning difficulties  | [ ]   | Consent 4 required |
| [ ]   | Serious neurological conditions | [ ]   | Liver disease |
| [ ]   | MI within last 6 weeks | [ ]   | Prosthetic heart valve  | [ ]  | infective endocarditis |
| **MRSA [ ]  Yes [ ]  No**  | **HIV [ ]  Yes [ ]  No**  | **Hep B/C [ ]  Yes [ ]  No**  |
| **Medication:**  |  |
|  |  |

**Investigations Performed**

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| H.Pylori Test  | Result | [ ]  Negative [ ]  Positive Date:       |
| Treatment |       |
| Performed | [ ]  Stool antigen [ ]  Breath Test [ ]  Serology (if negative as not indicative of current infection) |
| Imaging | [ ]  Barium swallow [ ]  Ultrasound[ ]  CT [ ]  XR [ ]  PPI>3/12 |
| Gastroscopy | Previous gastroscopy, results + date:       |
| **Please attach accompanying letter if you feel this would be beneficial** |

**History of presenting complaint** (include type and length of treatment given)

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**Gastroscopy Referral Pathway**

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| **A. Suspected Cancer Alarm Symptom** |
|  [ ]  Melaena / haemetemesis (consider admission) | [ ]  Suspicious barium meal / CT / US |
|  [ ]  Progressive unintended weight loss | [ ]  Epigastric mass |
|  [ ]  Dysphagia (interference with the swallowing mechanism that occurs within 5 seconds of having commenced swallow) | [ ]  Persistent vomiting and weight loss |
| **If yes please email referral within 24hrs** **If yes Please send by ERS**If no please go to section B |
| **B. Urgent Referral Symptoms** |
| [ ] > 55yrs with unexplained and persistent recent onset dyspepsia\* despite PPI and Test & Treat**\*Recent onset means NEW & not a recurrence (section C). Persistent defined as longer than expected >6wks. Unexplained after history/ G.P investigations** |
| Unexplained worsening dyspepsia with addition of:  [ ]  Barrett’s oesophagus  [ ]  Peptic ulcer surgery >20yrs ago [ ]  Atrophic gastritis / dysplasia / intestinal metaplasia |
| **If yes Please send by ERS**If no go to section C |
| **C. Routine Referral Symptoms** |
|  [ ]  Positive coeliac serology |
|  [ ]  >55yrs Ongoing dyspepsia (recurrent epigastric pain, bloating, nausea, vomiting) |
|  **Any age with dyspepsia and;**  [ ]  Family history of upper GI cancer [ ]  Ongoing NSAID use [ ]  Continued dyspepsia and whilst on **current** PPI therapy >3/12 |
| **If yes Please send by ERS** |
| Note that for patients under 55yrs, referral for Endoscopy is not usually necessary in the absence of alarm symptoms. Please refer to the NICE guidance on treating dyspepsia and acid reflux Sept 2014.<https://www.nice.org.uk/guidance/cg184>  |

**Patients should be free of PPI and H2 receptor agonists for 2 weeks before gastroscopy unless known Barrett’s Oesophagus.**

**Discussed urgent suspected cancer referral with patient? Yes** [ ]  **No** [ ]

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| For Booking office |
| Date received: | Appointment date/time | Patient notified: |

**Patient summary**

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| **Medical Problems:** |
| **Allergies:**  |

**Minimum Dataset:** (recordings in last 6months)

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| --- | --- |
| **Blood Pressure** |  |
| **Heart rate** |  |
| **Height**  |  | **Smoking Status**  |  |
| **Weight** |  | **Alcohol Intake** | ,  |
| **BMI** |  | **Exercise tolerance:**  |  |

**Radiology:** (In last 6 months)

**Blood Results (Last 12m):**

|  |  |  |
| --- | --- | --- |
| **FBC** |  | Hb , WCC , Plts , MCV , Neut  |
| **UE** |  | Na , K , Urea , Creat , eGFR  |
| **LFT** |  | ALT , Alk Phos , Bili , Alb , GGT  |
| **CRP** |  |  | **ESR** |  |
| **TFTs** |  | TSH , Free T4  | **INR** |  |
| **Bone** |  | Ca , Ca cor , Ca adj , Phos  |
| **Iron** |  | Ferritin , Iron Saturation , TIBC  |
| **Vitamins** |  | B12 , Folate  |
| **Lipids** |  | Chol , LDL , HDL ,Chol:HDL ratio , Tri  |
| **Random Glucose** |  | **Fasting Chol.** |  |
| **Fasting Glucose** |  | **HbA1c** |  |