Inhealth Endoscopy Ltd–West Oxfordshire Direct Access Community Endoscopy Service

Sigmoidoscopy and Colonoscopy Request Form

Please email this referral to: inl.inhealthreferrals@nhs.net
Fax: 0333 200 1163

ALARM SYMPTOMS: Patient with any of these symptoms should be referred into appropriate 2WW service
• Rectal bleeding and change in bowel habit > 40 years. • Rectal bleeding, no change in bowel habit > 60 years. • Change in bowel habit > 60 years. • Iron deficient anaemia of < Hb11 in men or <HB10 in post menopausal women. • Rectal mass • Abdominal mass

Patient Details		**Referrer details**	
Surname:		Referring GP:	
Forename:		Usual GP:	
Address:		Address:	
Postcode:		Postcode:	
Home tel:		Tel:	
Daytime tel:		Fax:	
Date of Birth			
NHS Number:			

INVESTIGATION REQUEST DETAILS		
Current Request		
Flexi Sigmoidoscopy ☐	Colonoscopy ☐	Colonoscopy and Gastroscopy ☐
Patient had previous endoscopy?	☐ Yes ☐ No	Date (DD/MM/YYYY):
If yes, what type of previous endoscopy?	☐ Gastroscopy ☐ Flexi Sigmoidoscopy ☐ Colonoscopy	

Reason for request:	

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Relevant clinical history:	

MEDICAL INFORMATION	
Note: If your patient requires sedation, they must have an escort home and have observation overnight.	
Note: Your patient will: • *Need To undertake bowel preparation* • *Be able to turn 180° (Left to right side) on a trolley* *Alternative imaging may be appropriate for frail/elderly patients not able to manage the above.*	
Does the patient have capacity to give informed consent?	☐ Yes ☐ No
Is this patient diabetic?	☐ Yes ☐ No If yes, is the patient Insulin dependent? ☐ Yes ☐ No
Is the patient on Warfarin?	☐ Yes ☐ No Duration:
Is the patient on Clopidogrel?	☐ Yes ☐ No Duration:

If you have answered 'yes' to any of the questions above, please ensure that you include any additional relevant clinical information above.

ENDOSCOPY SITE
Windrush Medical Centre ☐

Please repeat Patient Details below for clinical governance reasons:

Patient Name:
Patient NHS number:
Date of Referral:
GP Name:

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