# ENDOSCOPY UNIT DIRECT REFERRAL FORM

Bupa CROMWELL HOSPITAL

| Patient's Name: | | MRN: | Date of Birth: |
|---|---|---|---|
| Address:<br><br>Telephone Number: | | Referred by: | |
| Method of Payment | If by Insurance please provide Membership Number: | Self Pay | Yes ☐ |

| Test Required *Please Tick* | | | | | |
|---|---|---|---|---|---|
| OGD | ☐ | Bronchoscopy | ☐ | Flexible Sigmoidoscopy | ☐ |
| Colonoscopy | ☐ | Capsule Endoscopy | ☐ | Peg Insertion | ☐ |
| ERCP* | ☐ | Other Test please specify below | ☐ | Flexible Cystoscopy | ☐ |

Medical History/ Clinical Indication

Does the patient have of the conditions listed below? (please tick)

| | | | | | |
|---|---|---|---|---|---|
| • Hepatitis/liver Disease | Yes | No | • Type 1 Diabetes | Yes | No |
| • Ischaemic Heart Disease | Yes | No | • Type 2 Diabetes | Yes | No |
| • Valvular Heart Disease | Yes | No | • Infection Risk | Yes | No |
| • Respiratory Disease | Yes | No | • Bleeding Risk* | Yes | No |

Is the patient receiving medication? (*please list below*)
*If patient is on anticoagulant therapy they should seek advice before undertaking the procedure*

| Medication | Dose | Medication | Dose | Medication | Dose |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

| Blood results: *Must be available for those marked ** | HB: | INR: | Platelets: |
|---|---|---|---|

Time and Date of Procedure required:

Consultant:

Signature: _____ Date: _____