Endoscopy unit direct referral form

Cromwell Hospital

Endoscopy telephone: 0207 460 5605 **Email: endoscopy@cromwellhospital.com**

Patient's Name:	MRN:	Date of Birth:
Address: Telephone Number:	Referred by:	

Method of Payment	If by Insurance please provide Membership Number:	Self Pay	Yes ☐

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

Medical History/ Clinical Indication

Does the patient have of the conditions listed below? (please tick)					
• Heart/liver disease	Yes	No	• Type 1 diabetes	Yes	No
• Ischaemic heart disease	Yes	No	• Type 2 diabetes	Yes	No
• Heart valve 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: _____