

# Endoscopy unit direct referral form

Endoscopy telephone: 0207 460 5605

Email: endoscopy@cromwellhospital.com

Patient's Name:		MRN:		Date of Birth:		
Address:		Referred by:				
Telephone Number:						
Method of Payment	If by Insurance please provide Membership Number:			Self Pay	Yes <input type="checkbox"/>	
Test Required <i>Please Tick</i>	OGD	<input type="checkbox"/>	Bronchoscopy	<input type="checkbox"/>	Flexible Sigmoidoscopy	<input type="checkbox"/>
	Colonoscopy	<input type="checkbox"/>	Capsule Endoscopy	<input type="checkbox"/>	Peg Insertion	<input type="checkbox"/>
	ERCP*	<input type="checkbox"/>	Other Test please specify below	<input type="checkbox"/>	Flexible Cystoscopy	<input type="checkbox"/>
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: <i>Must be available for those marked *</i>	HB:		INR:		Platelets:	
Time and Date of Procedure required:						
Consultant:						

Signature: \_\_\_\_\_

Date: \_\_\_\_\_