

**Nottingham NHS Treatment Centre**

**Flexible sigmoidoscopy (direct to test)**

Z019: Patient referral

Please attach the completed document using the Choose & Book system**.** Incomplete referrals will be rejected.

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| **Declaration:** [ ]  I understand that I may only refer to this service having attended the relevant Launch event for Direct Access. [ ]  I am a member of NORCOMM or Nottingham East consortium. [ ]  I have read the local guidelines from the link http://www.acpgbi.org.uk/assets/documents/COLO\_guides.pdf on  rectal bleeding management and the patient fulfils the criteria for investigation. [ ]  I have explained to the patient that should they be diagnosed with haemorrhoids they may be offered  haemorrhoid banding at this appointment.  |

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|  **Section 1 Patient information (Please complete in BLOCK CAPITALS)**  |
| First name:       Mr [ ]  Miss [ ]  Mrs [ ]  Ms [ ]  Other:       Surname:       Date of birth:       **URGENCY:** These examinations will be performed within 2-4 weeks as standard |
| **Section 2 Medical information** |
| Clinical indications: [ ]  Rectal bleeding**Note these exclusions:** altered bowel habit, known inflammatory bowel disease, diarrhoea, those who will not tolerate bowel preparation at home, significant co‐morbidities, patients on anticoagulants, patients under the age of 16 years. Is the patient diabetic: Yes [ ]  No [ ] If yes: Insulin [ ]  Tablets only [ ]  Diet controlled [ ]   **The pathway is not suitable for brittle insulin dependent diabetics. Please include details in the free box at the end of this form.**Is the patient taking anticoagulants: Yes [ ]  No [ ] If yes, this is not the appropriate pathway - please refer for Gastroenterology opinion.Has the patient had a Barium enema, Flexible Sigmoidoscopy or Colonoscopy in the last 12 months:Yes [ ]  No [ ]  Please provide information in the comments section below.Is your patient able to consent for themselves Yes [ ]  No [ ]  If no, this is not the correct referral pathwayIs your patient immunosuppressed? Yes [ ]  No [ ] Is your patient high risk? (see below) Yes [ ]  No [ ] If yes, please state:HIV [ ]  Hepatitis B [ ]  Hepatitis C [ ]  Tuberculosis [ ] Other: (please state)      Is translator required? Yes [ ]  Language:       No [ ]  Is transport required? Yes [ ]  No [ ]  Disabilities: Hearing [ ]  Sight [ ]  Affecting mobility [ ]  |

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| **Section 3 Comments and any other details** |
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| **Any Communication Needs**       |

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| GP name:       |
| Referral date:       |

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