

**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 pathway  Is 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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