

corporate logo

**Nottingham NHS Treatment Centre**

**Gastroscopy (direct to test)**

Z020: 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 on dyspepsia management and the patient fulfills the criteria for investigation.  http://www.nice.org.uk/nicemedia/pdf/CG017fullguideline.pdf |

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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:** Urgent ( within 2 weeks)  Routine (within 4 weeks) |
| **Section 2 Medical information** |
| Clinical indications:  Dysphagia:  Heartburn:  Dyspepsia:  Atypical chest pain:  Weight loss:  Abdominal pain: Nausea/vomiting:  Previous ulcer:  GI bleed not requiring admission:    Is the patient taking H2RA’s or PPI’s: Yes  No  If yes: If **ROUTINE STOP** this medication prior to appointment date  (preferable for diagnosis)  If **URGENT CONTINUE** on this medication  (preferable for diagnosis repeat procedure)  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, must have had INR within week of investigation, continue normal daily dose.  Has the patient had barium meal or endoscopy in the last 12 months**:** Yes  No  If yes, please provide details:  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 |

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

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| GP name: |
| Referral date: |

CircleNottingham ¦ Nottingham NHS Treatment Centre ¦ Queen’s Medical Centre Campus ¦ Lister Road ¦ Nottingham ¦ NG7 2FT

**T**: 0115 970 5800 extension 10010

**F**: 0115 978 8765

**Contact**: nina.duffy@circlenottingham.co.uk

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