



**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 pathwayIs 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:       |

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