

Direct Access Endoscopy Referral Form – Upper GI/Gastroscopy

I have read the West Kent CCG Direct Access Upper GI Endoscopy guidelines: [] Yes
 All sections are mandatory to complete

Section 1 PATIENT INFORMATION (Please complete in BLOCK CAPITALS)

SURNAME Surname	Date of Referral Referral Date
FIRST NAME Given Name	Date of Birth Date of Birth
ADDRESS Home Full Address (stacked)	NHS number NHS Number
	Home Tel. Patient Home Telephone
	Mobile / Daytime Tel. Patient Mobile Telephone
	Transport Y N
	Mobility
	Interpreter Y N
	Ethnicity
	Language

Section 2 PRACTICE INFORMATION (Please use practice stamp if available)

Referring GP Referring User	Locum Y N
Practice Address	Telephone 01732 459255 Email xxxx@nhs.net

Section 3 REFERRAL CRITERIA (please TICK all applicable entries)

Patients under 55yrs with

- Recent onset of reflux or Acid related symptoms that fail to respond to any of:
 - adequate course of PPI []
 - lifestyle modifications (smoking, weight loss etc.); []
 - medication review eg stopping NSAID or aspirin []
 - H pylori eradication eg if serology or stool antigen positive. []
- New onset or changing dyspepsia associated with any of the following if not already under surveillance:
 - Known gastric dysplasia/atrophy or intestinal metaplasia []
 - Previous gastric surgery []
 - Pernicious anaemia []

Patients at least 55yrs age with ANY unexplained

- Treatment resistant dyspepsia []
- Low haemoglobin with upper abdominal pain []
- Raised platelet count with any of the following:
 - Nausea [] Vomiting []
 - Weight loss [] Reflux []
 - Dyspepsia [] Upper abdominal pain []
- Nausea/vomiting with any of the following:
 - Weight loss [] Reflux []
 - Dyspepsia [] Upper abdominal pain []

IF PATIENT HAS HEAMATEMESIS PLEASE URGENTLY CONTACT THE ACUTE TEAM FOR ASSESSMENT

Do not use this form if [NICE NG12 fast track suspected upper GI cancer criteria](#) are present – use Upper GI suspected cancer referral form for out-patient within 2 weeks

Section 4 CLINICAL INFORMATION - IS YOUR PATIENT? (please TICK all applicable entries)	
Taking H2RA's or PPI's? <input type="checkbox"/> No	<input type="checkbox"/> Yes (<i>Consider stopping for 2 weeks prior to appointment</i>) Details:
Diabetic? <input type="checkbox"/> No <i>(If brittle insulin treated diabetic either type 1 or 2 this pathway is <u>not</u> to be used)</i> Add details in free text box at end of form	<input type="checkbox"/> Yes Type 2 - Diet controlled <input type="checkbox"/> Yes Type 2 - Tablet controlled <input type="checkbox"/> Yes Type 1 - To minimise risk book 1st or 2nd on an am list
On anticoagulant therapy? <input type="checkbox"/> No	<input type="checkbox"/> Yes VitK antagonist (Warfarin/Phenindione: INR within 1 week of endoscopy, add to yellow book (bring) and continue normal dose) <input type="checkbox"/> Yes NOAC <input type="checkbox"/> Yes LMWH
Able to consent for themselves? <input type="checkbox"/> Yes	<input type="checkbox"/> No - THIS IS NOT THE CORRECT REFERRAL PATHWAY
On immunosuppressant drug? <input type="checkbox"/> No	<input type="checkbox"/> Yes Name of drug:
High risk? <input type="checkbox"/> No	<input type="checkbox"/> Yes Hepatitis C <input type="checkbox"/> Yes Hepatitis B <input type="checkbox"/> Yes HIV <input type="checkbox"/> Yes TB <input type="checkbox"/> Yes Other

Section 5 PAST MEDICAL HISTORY
Problems

Section 6 MEDICATION
Medication

Section 7 ADDITIONAL CLINICAL DETAILS

Please Email to mtw-tr.endoscopytwh@nhs.net

Or post to Endoscopy Office, Tunbridge Wells Hospital, Tonbridge Road, Pembury, Kent, TN2 4QJ