Location:

Practice Plus Group

Routine gastroscopy referral form

Please send all referrals via the NHS e-Referral System (ERS).
Visit our websites for more information on our patient safety acceptance criteria: **practiceplusgroup.com/referrals/how-to-make-an-nhs-patient-referral/#get-in-touch**

Referrer details

Date of referral
Referring GP
Practice name
GP no
GP practice
ICB name
Practice address
Telephone
Fax
Email address
Name of patient's GP
Name of GP practice

Patient details

Name
Address
Postcode
Telephone
Mobile
Date of birth
NHS no
Gender
Ethnicity
Height cm
Weight
Transport required ☐ Yes ☐ No
Transport requirements
Interpreter required ☐ Yes ☐ No
Interpreter requirements

Note: this service is not for suspected cancer referrals - refer to hospital under the two week wait rule.

Indication (please tick)

- ☐ **Dyspepsia >50 years of age**
- ☐ **Iron deficiency anaemia**
- ☐ **Melaena** (if within seven days -> refer for acute hospital care)
- ☐ **Persistent nausea and/or vomiting**
- ☐ **Unintended weight loss**
- ☐ **Family history of gastric or oesophageal cancer** (more than two first degree relatives)
- ☐ **Gastroesophageal reflux disease** (persisting despite appropriate treatment)
- ☐ **Surveillance of barrett's oesophagus** (please give previous surveillance history and reports)
- ☐ **Painful or difficult swallowing** (dysphagia)
- ☐ **Confirmation of suspected coeliac disease by D2 biopsies**

Relevant history and recent management

BP Date Weight (kg) BMI

Past relevant medical and surgical history

Referral requirements for day case procedure

•Escorted home following procedure. • Accompanied at home for 24 hours following procedure. • Access to telephone at home.

Other information required, GP summary

- Allergies? Please state
- Diabetes ☐ Yes ☐ No ☐ If yes, insulin/oral ☐ medication/diet
- Regular medication? Please state or attach list

☐ **Confirm GP summary is attached.**

Further information required

☐ Computerised summary outlining current medical history, medication and allergies (please tick and attach or referral may be returned).
☐ Patient is diabetic (please give details of management (insulin/medication/diet)).
☐ A history of previous endoscopies and findings is attached (please tick if attached).
☐ Current use of anti-coagulants/anti-platelets.

Signed by referring clinician

Date

(If computer generated referral – please insert name and date here. By adding your name, dating, and sending this referral you are indicating your consent to the terms of this referral.)

Notes

If you have any questions about your referral, please call **0117 906 1800.**