Milton Keynes University Hospital NHS
NHS Foundation Trust

# Direct to Test Flexible sigmoidoscopy

**Please attach this form to your E-referral (Choose and Book).**
If you experience any problem, contact the Endoscopy Booking co-ordinator on 01908 996907 or 01908 996905.

Note that we do not accept referrals via fax or post. E-referrals that do not have this pro-forma attached will be rejected.

| **Patient Details** | | |
|---|---|---|
| Name: | | Date of Birth: |
| | | Sex: Male/Female |
| Address: | | NHS Number: |
| | | Hospital Number: |
| | | Interpreter Required Yes/No |
| Post Code: | | First Language: |
| Please tick number(s) for use in the next 24 hours | ✓ | |
| Telephone Home: | | |
| Work: | | |
| Mobile Telephone: | | |
| **GP Details** | | |
| GP Name: | | Telephone Number: |
| Practice: | | Fax Number: |
| | | Date of Referral: |

## *Flexible sigmoidoscopy*

| | Yes | No |
|---|---|---|
| Altered bowel habits with loose stools without bleeding in under 55yrs | | |
| Assessment of flare up of colitis or suspected colitis | | |
| Diarrhoea after NEGATIVE Coeliac serology and Stool cultures | | |
| Rectal bleeding in a patient under 50yrs | | |
| Persistent Left iliac fossa pain and/or rectal symptoms | | |

**Bowel prep: Phosphate enema** (self-administration 1 hr before leaving home)

**TO BE PRESCRIBED BY GP AT THE TIME OF REFERRAL**

**Please fill relevant medical history on page 2**

Milton Keynes University Hospital NHS
NHS Foundation Trust

## Endoscopy Unit Health Screen Form for risk assessment

Name________________________________ DOB_________________

MRN________________ Contact telephone number_________________

| **Does the patient have a history of:** | **Yes** | **No** | **If yes, please give details** |
|---|---|---|---|
| Cardiac: IHD, MI, heart failure | | | |
| **Do they have a:** Pacemaker, ICD, CRT Coronary stents, Mechanical heart valve (s) | | | |
| Stroke in the last 3 months | | | |
| Respiratory: COPD, Asthma, Emphysema | | | |
| Diabetes | | | |
| Epilepsy | | | |
| Blood disorders | | | |
| Abdominal surgery such as: **Gastrectomy, Bariatric, Hysterectomy, Bowel surgery** | | | |
| Kidney or liver failure, Dialysis, Organ transplant | | | |
| Hypertension | | | |

| **Does the patient take any of the following medication:** | **Yes** | **No** | **If yes, please give details of dose, reason for medication and timescale when medication started** |
|---|---|---|---|
| Iron tablets (Stop 1 week before endoscopy) | | | |
| **Anti-coagulant therapy:** | | | |
| Warfarin | | | a. Indication:<br>b. Can this be stopped for 5 days? yes / no |
| Clopidogrel (Plavix) | | | Indication: |
| Aspirin | | | |
| Dalteparin/ Heparin | | | |
| **Diabetic medication:** | | | |
| Insulin | | | |
| Tablets | | | |
| **Does the patient have any known allergies?** | **Yes** | **No** | **If yes, any details;** |

| **Please list any other medication that the patient is currently taking** | **Dose** | **How often** | **Any comments** |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| **Any other relevant comments or information** | | | |

Signature___________________________________ Date________________________

Print Name__________________________________