University Hospitals Bristol NHS
NHS Foundation Trust

BRISTOL ROYAL INFIRMARY
LOWER GASTROINTESTINAL ENDOSCOPY REFERRAL FORM

Please complete all appropriate sections of this form. Incomplete forms will result in a delay in listing and may be returned to the referrer.

Please send completed forms to: Endoscopy Booking Clerk, QDU, Level 4, Queens Building, BRI Tel: 0117 3420040

1. PATIENT DETAILS	
BRI / NHS Number:	Patient Address:
Surname:	
Forenames:	
Date of Birth:	
Sex: **M / F** Age:	Patient Tel. No:
IF LABELS ARE FAINT, PLEASE MAKE HOSP NUMBER AND PATIENT NAME LEGIBLE	
GP Name:	Inpatient Ward:
GP Address:	Ward Ext. No:
	Consultant:
	Ref Dr & Bleep:
	Date of referral:
GP Tel. No:	Signature:

2. PROCEDURE REQUIRED ☐ Urgent ☐ Routine **Time specified:**
☐ Colonoscopy ☐ Sigmoidoscopy ☐ Lower EUS ☐ Other (specify):
3. CLINICAL DETAILS
4. BOWEL PREP ☐ Klean Prep ☐ Picolax ☐ Phosphate enema ☐ None required

5. MEDICAL HISTORY		
Weight: Mobility:		Transport Req? Chair ☐ Trolley ☐
☐ Diabetes IDDM☐ NIDDM ☐	☐ Ischaemic heart disease	☐ Dementia
☐ Epilepsy	☐ MI within the past 6 weeks	☐ Immuno compromised
☐ Respiratory compromised		☐ Valvular heart disease (require antibiotics)
☐ Serious neurological conditions		☐ Previous colorectal surgery
Any known infections? MRSA ☐ HIV ☐ Clos Diff ☐ Other:		
Further details:		

6. ALLERGIES (including food, drugs & materials):	Anticoag ☐YES ☐NO Which drug: Reason: INR: Date:

7. BOOKING DETAILS (Endoscopy Use Only) Request received:	
Inpatient	**Outpatient**
Date booked:	Listing letter sent:
By whom:	Appointment booked:
Procedure due:	At (time):
At (time):	Transport booked:
	By whom: