Endoscopy Procedure Request Form

Cleveland Clinic London

Please complete all known information on this form and email to CCLREFERRALS@ccf.org or fax to 0207 890 4466

For referral appointments by telephone please call our dedicated Referrals Line on 0203 423 7777

Patient Details	**Referrer Details**
Title:	Name:
Surname:	Practice name:
First name:	Street address:
Sex:	Postcode:
Date of birth (DD/MM/YYYY):	Telephone No.:
NHS No. (If known):	Email:
Street address: Postcode:	**Payment Details**
Telephone / Mobile:	☐ Private Health insurance ☐ Embassy patient ☐ Self-Funding
Email:	

Clinical Information

Test Required
☐ Gastroscopy ☐ Capsule Endoscopy (Pill Cam) ☐ Colonoscopy
☐ Bravo pH Test ☐ Endoscopic Ultrasound ☐ Flexible Sigmoidoscopy
☐ Other - Please specify:

Indication for test and reason for referral:

Is sedation required? ☐ Yes ☐ No

Drug & Medical History

Anticoagulant / Antiplatelet Therapy	☐ Yes	☐ No	Rheumatoid Arthritis	☐ Yes	☐ No
Aspirin	☐ Yes	☐ No	Cardiovascular (specify in Other)	☐ Yes	☐ No
Diabetes - Insulin or Tablet	☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No
Infection Risk (HIV / TB / Hepatitis / CJD)	☐ Yes	☐ No	Respiratory (specify in Other)	☐ Yes	☐ No

Other (Please specify:

Does the patient have any allergies? ☐ Yes ☐ No
If yes, please describe

Are there any accessibility / mobility concerns? ☐ Yes ☐ No
If yes, please describe

Bowel Preparation

By completing this section, you confirm you have completed a clinical assessment to ensure there are no contraindications for the use of the bowel preparation and that any necessary precautions required have been arranged.

☐ Moviprep ☐ Picolax ☐ Plenvu ☐ Phosphate Enema

I authorise this patient to undergo the above procedure and I hereby prescribe the above listed bowel preparation.

Signature: _____ Date: _____