

## Colonoscopy Refer (FHN)

Referral of Patients with  
Suspected Bowel Cancer - 2 Week Rule

Please complete form in full as it will not be reviewed by a medical professional prior to appointment being allocated. Fax immediately to 01609 762149

<b>Referring doctor:</b> Address:   Postcode: Date of decision to refer: Date of referral: Tel no: Fax no:	<b>Patient name:</b> Address:   Postcode: Date of birth:                      Age: Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female Tel no (home): Mobile no: Hospital no: NHS number:
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**GP preference if Colonoscopy negative:**

☐ Refer to clinic    ☐ Return to GP    ☐ At discretion of Endoscopist  
 Additional letter enclosed: ☐ Yes    ☐ No

**Alarm symptoms:**

- ☐ PR bleeding persistently without loose stools and without anal symptoms > 50 years old  
☐ PR bleeding & loose / more frequent stools for > 6 weeks  
☐ Loose / more frequent stools > 6 weeks > 50 years old  
☐ Iron Deficiency Anaemia (IDA) with no obvious cause (men or post-menopausal women)  
☐ Right sided mass  
☐ Rectal Mass                      (Note that if patient has IDA they will usually be invited for gastroscopy with duodenal biopsy at the same time as colonoscopy.)

**Patient fitness and bowel preparation: This form should be completed with reference to the accompanying users' guide. For this method of referral to be appropriate without secondary care assessment you must be able to tick the box in each section and sign accordingly. All 5 boxes must be ticked before the referral can be processed.**

**Patient fitness:** ☐ Fit for day case Colonoscopy with home bowel prep

**Contra-indications to bowel preparation:** ☐ Confirm the absence of absolute contra-indications to bowel preparation

**Concomitant Drugs:** ☐ Confirm patient is not taking drugs with adverse effect on safety of bowel preparation or able to stop drugs for required interval prior

**Co-morbidity & Risk factors:**

☐ Confirm the absence of bowel preparation related cautions

**Responsibility for bowel preparation accepted by requesting clinician subject to a pre-assessment clinic visit at FHN – sign below**

☐ Confirm booking leaflet and both verbal and written information about bowel preparation given to patient

Signed: ..... Print name: ..... GMC number: ..... Date: .....

**If it is not possible to fully complete this form and sign to confirm responsibility for bowel preparation this method of referral is not appropriate. If the form is still submitted the patient will be called to a 2WR clinic appointment & a letter of referral is required.**

**Further Information:**

**Has patient had a previous Colonoscopy for similar symptoms?** ☐ Yes    ☐ No    Date of test: .....

**Is this patient Diabetic?** ☐ Yes    ☐ No

Diabetic: ☐ Diet only    ☐ Tablets only    ☐ On Insulin: Name of insulin ..... Number of daily injections / day .....

**Is this patient on Warfarin?** ☐ Yes    ☐ No

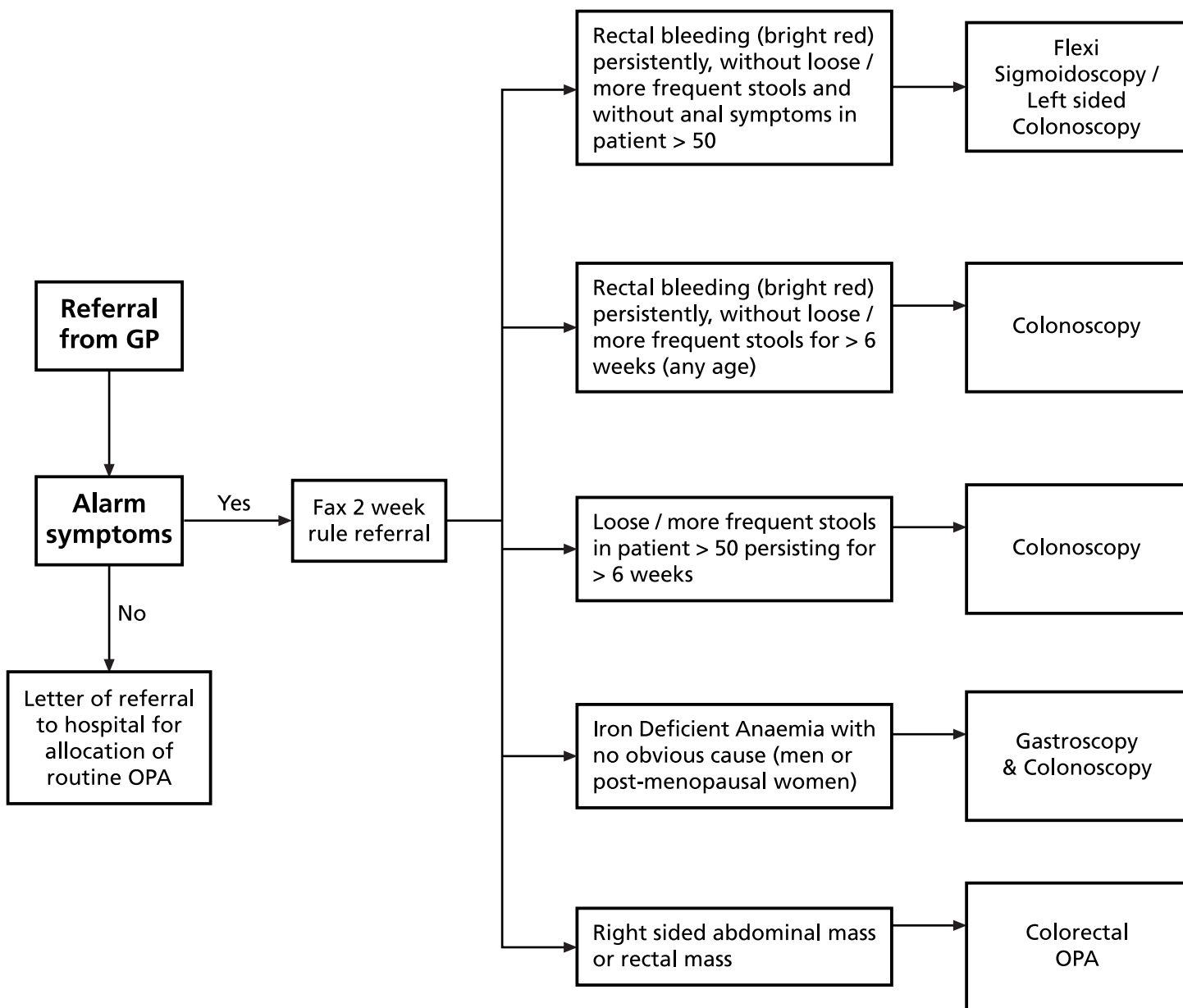
**On Aspirin or other anti-platelet agent?** ☐ Yes    ☐ No    List: .....

Indications: ☐ AF without valvular heart disease    ☐ AF with valvular heart disease    ☐ Previous CVA / DVT or PE

☐ Prosthetic valve    ☐ IHD    ☐ Other (detail) .....

## Direct to Test Lower GI Endoscopy

### Symptomatic Bowel Referral Guidelines



#### Alarm Symptoms:

- PR bleeding & loose / more frequent stools for > 6 weeks
- PR bleeding persistently without anal symptoms > 50 years old
- Loose / more frequent stools > 6 weeks > 50 years old
- IDA with no obvious cause (men or post-menopausal women)
- Right sided or rectal mass