

NHS Foundation Trust

2 Week Rule Referral Proforma

Referral of Patients with Suspected Upper GI 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 this form immediately to 01642 282826

Booking leaflet given to nation: Yes

Booking leaflet given to patient: Yes 🗌	
Referring doctor:	Patient name:
Address:	Address:
	Postcode:
Postcode:	Date of birth: Age:
Date of decision to refer:	Sex: Male Female
	Tel no (home):
Date of referral:	Mobile no:
Tel no:	Hospital no: NHS number:
Fax no:	Patient previously visited this hospital? Yes No
GP preference if upper GI endoscopy negative:	
Refer to clinic Return to GP	At discretion of Endoscopist
Alarm symptoms: Dysphagia Unintentional weight loss	
Patient fitness: Fit for day case Gastroscopy: Yes No (If no then refer by letter to 2WR clinic) N.B. If patient wanting sedation, must be able to organise escort home and observation overnight Is patient able to give informed consent: Yes No (If no then refer by letter to 2WR clinic) Has patient had a previous Gastroscopy for similar symptoms: Yes No Date of test:	
Diabetic: Diet only Tablets only	
On Insulin: Name of insulin	
Is this patient on Warfarin? Yes No	
On Aspirin of other anti-platelet agent?	
Must continue: Yes No AF without valvular heart disease AF with valvular heart disease Previous CVA / DVT or PE Prosthetic valve Other (detail)	
H Pylori negative: Yes No Not known On PPI/H2 Antagonist: Yes No Duration:	Pt responded: Yes No
Clinical examination / other relevant history / medication / referral outside guidelines: Please attach letter with additional detail if appropriate	
For Office Use: Date received: Date appt booked:	Date 1st seen:
Malignant: ☐ Yes ☐ No If not seen, please specify:	

Action re Warfarin / antiplatelet drugs: |

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Upper GI Referral Guidelines

