Roscommon University Hospital

GASTROINTESTINAL ENDOSCOPY SERVICE

REQUEST FORM

Affix addressograph here

Patient Name: Sex: M / F Date of Birth: Address: Hospital Number: Phone: (H): (W) Phone: (Mobile) Interpreter Required: Y / N Language:	Referring Doctor: Address: Phone: Fax: CC (If Necessary): Signature: Date:

❑ **Mr. McMullin** ❑ **Mr. Eldin** ❑ **Any Available**

❑ **GASTROSCOPY**

Indication (Please provide details below)

- ❑ Bleeding
  - ❑ Haematemesis/malaena
  - ❑ Iron Deficient Anaemia
- ❑ Dysphagia
- ❑ Loss of weight
- ❑ Pain
  - ❑ Dyspepsia
  - ❑ Reflux
  - ❑ Atypical chest pain (Cardiac cause excluded)
- ❑ Nausea/vomiting/loss of appetite
- ❑ Barrett's screening
- ❑ Small bowel biopsy – celiac screening
- ❑ Other (details below)

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❑ **COLONOSCOPY** ❑ **PROCTOSCOPY**

❑ **FLEXIBLE SIGMOIDOSCOPY**

Indication (Please provide details below)

- ❑ PR Bleeding
  - ❑ Bright ❑ Dark/mixed
  - ❑ FOBT ❑ Iron Deficient Anaemia
- ❑ Altered bowel habit
  - ❑ Diarrhoea ❑ Constipation
- ❑ Abnormal imaging (attach report)
- ❑ Surveillance
  - ❑ Previous Ca ❑ Previous Polyps
  - ❑ Family history Ca (details below) ❑ IBD
- ❑ Loss of weight
- ❑ Other (details below)

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PAST MEDICAL HISTORY:

**Has patient had a previous scope? Yes ❑ No ❑ If yes, when? _____

ANTI-COAG/ANTI-PLATELET THERAPY:

	Can it be stopped?
❑ None	
❑ Aspirin	❑ Yes ❑ No
❑ Clopidogrel	❑ Yes ❑ No
❑ Warfarin	❑ Yes ❑ No
❑ Other _____	❑ Yes ❑ No

COMORBIDITIES (Must be completed):

- ❑ None
- ❑ Cardiac
- ❑ Respiratory
- ❑ Renal
- ❑ Diabetes: Type 1/Type 2
- ❑ History of MRSA ❑ C. Diff

ALLERGIES:

EXTRA INFO/MEDICATIONS:

Please post form to Central Referrals Office, Roscommon University Hospital, Athlone Road, Roscommon 090 6632382 or Fax fully completed form to: 090 6625137. Any enquiries phone: 090 6632208/2203

Incomplete/inadequate referrals will be returned to the referring Doctor.

Patients may be referred to Endoscopy Out Patient Clinic for assessment prior to procedure [Revised 2017]

OFFICE USE ONLY:

RECEIVED IN ENDOSCOPY UNIT: _____

REVIEWED AND PRIORITISED BY ENDOSCOPY REGISTRAR/CONSULTANT: _____

Urgent: _____ **Routine: _____**

Signed: _____

Date for Procedure: _____

Comments: _____

_____

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Appointment/Information Sent:

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