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| **PATIENT DETAILS** | | | | | |
| **Surname: <Patient Name>** | | | **Forename: <Patient Name>** | | **DOB: <Date of Birth>** |
| **Address:** | | | **NHS Number:** | | **Referring GP Details**  **Address:**  **Organisation Code:**  **Contact Tel No:**  **\*Referral date:** |
| **Mobile Tel No:** | | | **Is an interpreter required?**  Yes  No  If yes, please specify the patients preferred language: | |
| **Home Tel No:** | | |
| **Smoking status:**  Yes  No  Ex-Smoker | | |
| **BMI** | | **Weight** |
| **Is the patient diabetic** | | Yes  Please specify  No | **Insulin dependent** | | **Non-insulin dependent** |
| **\*Patient on Anticoagulation/antiplatelet medication?** | | | Yes  No | Please specify Indication |  |
| **Warfarin**  **Apixaban**  **Rivaroxaban**  **Aspirin**  **Clopidogrel**  **Other** | | | | | |
| **\*Patient has capacity to consent?** | | | Yes  No |  | |
| **\*Does the patient consent to be contacted by Text message?** | | | Yes  No |  | |
| **REQUEST FOR URGENT FLEXIBLE SIGMOIDOSCOPY FOR UNEXPLAINED RECTAL BLEEDING**  **≥40 YEARS, FIT NEGATIVE (<10 µg HB/g),** | | | | | |
|  | |  |  | | --- | --- | | **BLOOD RESULTS** | | | **Hb** g/dl  **MCV** fL | Date of Results |   **All of the following criteria must be met for a referral:**  **(Tick below)**  **Aged 40 years or over AND**  **FIT NEGATIVE (enter result** µg HB/g) **AND**  **Have unexplained RECTAL BLEEDING**  \*For FIT POSITIVE (≥10 µg HB/g) Rectal Bleeding, please use the 2WW Colorectal form. | | | | |
| **REQUEST FOR FIT NEGATIVE CLINIC**  **≥50 YEARS, FIT NEGATIVE (<10 µg HB/g) AND CHANGE IN BOWEL HABITS (Looser/more frequent stools ≥ 6 weeks)** | | | | | |
|  | **All of the following criteria must be fulfilled for a referral:**   |  |  | | --- | --- | | **BLOOD RESULTS** | | | **Hb** g/L  **MCV**       fL  TTG      UI/ml  TSH       mIU/L  FT4      pmol/L  Stool MCS…… | Date of Results |   **(Tick below)**  **Aged 50 years or over AND**  **FIT NEGATIVE (enter result** µg HB/g) **AND**  **Have Persistent Change in Bowel Habit (looser/more frequent stools for ≥6 weeks) AND**  **FBC/TFT/Coeliac screen/Stool MCS within 2 months**  \*For FIT POSITIVE (≥10 µg HB/g) Change in bowel habit, please use the 2WW Colorectal form. | | | | |
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| **\*WHO PERFORMANCE STATUS - PLEASE CONFIRM PATIENTS PERFORMANCE STATUS AT TIME OF REFERRAL** | |
| 0 | Fully active, able to carry on all pre-disease performance without restriction |
| 1 | Restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature, e.g. light housework, office work |
| 2 | Ambulatory and capable of all self-care but unable to carry out any work activities up and about more than 50% of waking hours |
| 3 | Capable of only limited self-care, confined to bed or chair more than 50% of waking hours |
| 4 | Completely disabled. Cannot carry on any self-care. Totally confined to bed or chair |

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| **\*CLINICAL HISTORY/ INFORMATION AND RECENT TEST RESULTS:**  **Please include detailed history of presenting complaint and relevant medical history, co-morbidities, current medication, allergies and/or any other recent investigations.** |
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