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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 [ ]  NoIf 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),**  |
| [ ]  |

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| **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:**

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| **BLOOD RESULTS**  |
| **Hb** g/L**MCV**       fLTTG      UI/ml TSH       mIU/L FT4      pmol/LStool 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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