

## Procedure Request Form

Please complete all sections of the form. By completing this form, you confirm you have the consent required to share this information.

### PATIENT DETAILS

TITLE:	FORENAME(S):	SURNAME:
DATE OF BIRTH:	GENDER: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE <input type="checkbox"/> OTHER	
RESIDENTIAL ADDRESS:		POSTCODE:
TELEPHONE:	MOBILE:	
EMAIL:		

### PROCEDURE AND ENDOSCOPIST DETAILS

REFERRER NAME:	ENDOSCOPIST:
REFERRER ADDRESS:	
REASON FOR REFERRAL:	
PROCEDURE(S): <input type="checkbox"/> Colonoscopy <input type="checkbox"/> Gastroscopy <input type="checkbox"/> Flexible Sigmoidoscopy <input type="checkbox"/> Endoscopic Ultrasound <input type="checkbox"/> Other, please specify:	INDICATION AND CLINICAL DETAILS FOR EXAMINATION:  <input type="checkbox"/> Bravo PH Test <input type="checkbox"/> Pill Cam – capsule endoscopy
SEDATION:	
DATE & TIME OF PROCEDURE (if known):	ESTIMATED PROCEDURE DURATION:

### DRUG & MEDICAL HISTORY (tick yes if relevant)

ANTICOAGULANT/ANTIPLATELET:	<input type="checkbox"/> YES <input type="checkbox"/> NO	RHEUMATOID ARTHRITIS:	<input type="checkbox"/> YES <input type="checkbox"/> NO	OTHER (PLEASE STATE):
ASPIRIN	<input type="checkbox"/> YES <input type="checkbox"/> NO	CARDIOVASCULAR PACEMAKER	<input type="checkbox"/> YES <input type="checkbox"/> NO	
DIABETES - INSULIN / TABLET	<input type="checkbox"/> YES <input type="checkbox"/> NO	RESPIRATORY	<input type="checkbox"/> YES <input type="checkbox"/> NO	
ALLERGIES (PLEASE LIST IN OTHER)	<input type="checkbox"/> YES <input type="checkbox"/> NO	ABILITY TO CONSENT	<input type="checkbox"/> YES <input type="checkbox"/> NO	
INFECTIVE (E.G. HIV / TB / HEPATITIS) CJD RISK	<input type="checkbox"/> YES <input type="checkbox"/> NO	MOBILITY PROBLEMS (Please specify)	<input type="checkbox"/> YES <input type="checkbox"/> NO	

### BOWEL PREPARATION

By completing this section, you confirm you have completed a clinical assessment to ensure there are no contraindications for the use of the bowel preparation and that any necessary precautions required have been arranged.

<b>BOWEL PREPARATION:</b> <input type="checkbox"/> Moviprep <input type="checkbox"/> Picolax <input type="checkbox"/> Plenuv <input type="checkbox"/> Phosphate Enema	<b>DELIVERY METHOD:</b> <input type="checkbox"/> Patient visit pharmacy <input type="checkbox"/> Pharmaciege
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### EXTRA REQUIREMENTS

SPECIAL EQUIPMENT REQUIREMENTS:	WHEELCHAIR ACCESS:
INTERPRETER REQUIRED: <input type="checkbox"/> Yes, please confirm language:	
OTHER:	DIETARY REQUIREMENTS:

### REFERRER DETAILS

GP/REFERRER NAME :	GP/REFERRER PRACTICE :
GP/REFERRER CONTACT NUMBER:	GP/REFERRER EMAIL:

### PAYMENT DETAILS (IF KNOWN)

<input type="checkbox"/> Bill to Patient	<input type="checkbox"/> Bill to Insurer INSURANCE COMPANY:	<input type="checkbox"/> Bill to Embassy EMBASSY:	<input type="checkbox"/> Bill to referrer AGENCY NAME:
	MEMBERSHIP NO:	LETTER OF GUARANTEE: <input type="checkbox"/> (Please attach)	
	AUTHORISATION CODE:		

NAME :	SIGNED :	DATE :
PROFESSIONAL REG NO:		

Please attach the last clinic letter, any relevant test results and any additional documentation to this form and submit to us via one of the following:

**E:** bookings.endoscopy@onewelbeck.com **A:** OneWelbeck Endoscopy Centre, 1 Welbeck Street, London W1G 0AR **T:** +44 (0)20 3653 2004