

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: <input type="checkbox"/> Yes <input type="checkbox"/> No	
DATE & TIME OF PROCEDURE (if known):	ESTIMATED PROCEDURE DURATION:

GP (OR OTHER REFERRER) DETAILS

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

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)	<input type="checkbox"/> Yes <input type="checkbox"/> No	MOBILITY PROBLEMS (Please specify)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
CJD RISK	<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.

BOWEL PREPARATION: <input type="checkbox"/> Moviprep <input type="checkbox"/> Plenvu <input type="checkbox"/> Picolax <input type="checkbox"/> Phosphate Enema	DELIVERY METHOD: <input type="checkbox"/> Patient visit pharmacy <input type="checkbox"/> Pharmaciierge
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PAYMENT DETAILS

TYPE: Self-funding <input type="checkbox"/> Insured <input type="checkbox"/> Embassy <input type="checkbox"/> Other (please complete below sections as appropriate)		
INSURANCE COMPANY:	MEMBERSHIP NO:	AUTHORISATION CODE:
EMBASSY:	LETTER OF GUARANTEE: <input type="checkbox"/> Yes (please attach)	

EXTRA REQUIREMENTS

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

DECLARATION & FORM SUBMISSION

I authorise this patient to undergo the above procedure and I hereby prescribe the above listed bowel preparation.

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

E: bookings.endoscopy@onewelbeck.com
 F: +44 (0) 20 3327 0096
 A: Bookings, OneWelbeck Endoscopy Centre, 1 Welbeck Street London W1G 0AA
 T: +44 (0) 20 3653 2004