Beacon Hospital

- Scheduling Contacts: PH: (01)293 8656 FAX: (01)293 7552
- Email: endoscopyappointments@beaconhospital.ie

ENDOSCOPY PROCEDURE REFERRAL FORM

PATIENT DETAILS or ADDRESSOGRAPH:

Name (as per legal document):

Male ◯ **Female** ◯

DOB: / /

Address:

Patient Phone No:

Patient Email:

PROCEDURE REQUIRED & INSURANCE CODES:

Colonoscopy / Code (455) ☐

Upper GI Endoscopy / Code (194) ☐

Flexible- Sigmoidoscopy / Code (450) ☐

Other _____ ☐

Insurance Details: Patient to contact their own insurance company and check they have cover.

_____

Procedure Date: _____

CLINICAL INFORMATION:

Has patient had previous endoscopy procedures Y◯ N◯

If yes, please provide year: _____ **OGD** ☐ **COLON** ☐

Allergies: Y◯ N◯

Specify: _____

MEDICATIONS:

Anticoagulants: (Warfarin, Aspirin, Plavix) Y◯ N◯

Novel Oral Anticoagulants: (Xarelto, Pradaxa, Apixaban) Y◯ N◯

Diabetic: **NO** ◯ **NIDDM** ◯ **IDDM** ◯

Iron Tablets: Y◯ N◯

Relevant Other Medications:

Moviprep Prescription given: Y◯ N◯

REASON / INDICATION FOR PROCEDURE:

UPPER GI SYMPTOMS

Dyspepsia ☐ Reflux/Heartburn ☐ Other ☐

Dysphagia ☐ Epigastric Pain ☐ Anemia ☐

Bloating ☐ Nausea ☐ Vomiting ☐

UPPER GI SYPMTOMS:

Hematemesis / Melena ☐ Weight Loss ☐

Barrett's Oesophagus ☐ Duodenal Biopsy ☐

Varices Assessment ☐ Other ☐

COLORECTRAL SYMPTOMS

Rectal Bleeding: Acute ☐ Chronic ☐

Altered Bowel Habit Acute ☐ Chronic ☐

Abdominal/ Rectal Mass ☐

Iron Deficiency Anemia ☐

Abdominal Pain ☐

IBD Assessment / Surveillance / Polyp Surveillance ☐

Other ☐

COLORECTAL SCREENING:

Average Risk (Age<50) ☐

History of Adenomatous Polyps ☐

History of Colorectal Cancer ☐

Family History ☐

Haemoccult +ive Stool (FIT TEST) ☐

ADDITIONAL INFORMATION/OTHER INDICATIONS:

PLEASE COMPLETE ALL AREAS. JAG / JCI STANDARDS REQUIRES A MINIMUM OF HEART AND LUNG ASSESMENT- PRE-SEDATION.

PAST MEDICAL AND SURGICAL HISTORY: Y◯ N◯ Unknown◯

If > 30 days from initial review - update medical/surgical history below:

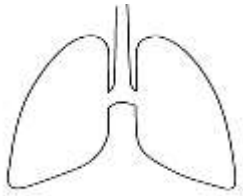
Surgical History:

Medical History:	Tick:	Specify:
Heart Murmurs	Y◯ N◯ Unknown◯	
COPD	Y◯ N◯ Unknown◯	
Asthma	Y◯ N◯ Unknown◯	
Hypertension/MI/ IHD/CVA	Y◯ N◯ Unknown◯	
ICD / Pacemaker	Y◯ N◯ Unknown◯	
Epilepsy	Y◯ N◯ Unknown◯	
Sleep Apnoea	Y◯ N◯ Unknown◯	
Blood Disorder	Y◯ N◯ Unknown◯	

PSYCHOSOCIAL EXAMINATION HISTORY: Y◯ N◯ N/A◯

If yes, please specify. **Sedative or Mood-Altering medication**

PHYSICAL EXAMINATION HISTORY:



Heart Sounds:

If > 30 days from initial assessment update below:

GP DETAILS:

Name: **IMC No.** **Date:**

Address: **Phone:**

Any significant changes in patient condition since assessment date to be documented at time of admission or prior to an outpatient procedure

This assessment has been reviewed and / or verified on admission to Beacon Hospital: Clinician Name: _____ **IMC NO:** _____ **Date:** _____