

**Digestive Hub Referral Form**

**PLEASE NOTE: THIS PATHWAY IS NOT FOR PATIENTS WITH SUSPECTED CANCER**

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Urgency** | | | | | | | | | | |
| Routine (assessed within 6 weeks) | | | | | Urgent (assessed within 2 weeks)  Please indicate reason: | | | | | |
| **Patient Details** | | | | | | | | | | |
| Name; Full Name | | | | | | | Date of Birth: Date of Birth | | | |
| Address: Home Full Address (single line) | | | | | | | Sex: Gender(full) | | | |
| Post Code: Home Address Postcode | | | | | | | Ethnicity: Ethnic Origin | | | |
|  | | | | | | | NHS Number: NHS Number | | | |
| Please tick number(s) for use in the next 48 hours ✓ | | | | | | | Hospital Number: Hospital Number | | | |
| Daytime Telephone: Patient Home Telephone | | | | | |  | UBRN: | | | |
| Work Telephone: Patient Work Telephone | | | | | |  | First Language: Main Language | | | |
| Mobile Telephone: Patient Mobile Telephone | | | | | |  | Interpreter Required: | | | (tick if Yes) |
| **Cognitive, Sensory or Mobility Impairment** | | | | | | | | | | |
|  | **Cognitive** |  | **Sensory** |  | | **Mobility** | |  | **Disabled access required** | |
| **Please include relevant details:** | | | | | | | | | | |
| **MANDATORY BOX FOR ALL PATIENTS – WHO PERFORMANCE SCORE**  **Score to establish if patient is suitable for straight to test CT, endoscopy or ultrasound prior to first outpatient appointment.**   |  |  | | --- | --- | |  | 1. 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. | |  | 1. Ambulatory and capable of all self-care but unable to carry out any work activities. The patient is up and about 50%+ of waking hours. | |  | 1. Capable of only limited self-care; confined to bed or chair more than 50% of waking hours. | |  | 1. Completely disabled; cannot carry out any self-care. The patient is totally confined to bed or chair | | | | | | | | | | | |
| Are there any barriers that would prevent the patient receiving a virtual consultation? (e.g. hearing impairment, language barrier, cognitive impairment, learning difficulties, no access to required technology)  **No  Yes** Please list: | | | | | | | | | | |
|  | I have counselled the patient regarding the referral process and offered the patient information leaflet | | | | | | | | | |
| **SUITABLITY FOR TELEPHONE TRIAGE/STRAIGHT TO TEST ENDOSCOPY PATHWAY. PLEASE COMPLETE THIS SECTION FOR ALL PATIENTS**  If the answer to ALL following questions is no then the patient is suitable for telephone triage and the ‘straight to test’ endoscopy pathway, where appropriate. All patients must have up to date renal functions (within 3 months) as they may be sent for straight to test CT prior to first outpatient appointment. | | | | | | | | | | |
| **Y  N** | Patient has dementia | | | | | | | | | |
| **Y  N** | Patient has learning disability | | | | | | | | | |
| **Y  N** | Patient has physical impairment that prevents patient being ambulant from a wheelchair | | | | | | | | | |
| **Y  N** | Patient is on anticoagulant or antiplatelet agents (expect aspirin) | | | | | | | | | |
| **Y  N** | Patient has had other gastrointestinal investigations in the last 12 months (abdominal imaging or gastrointestinal endoscopy). Please ensure relevant details are included, including name of the specialist and hospital where the investigations were performed. | | | | | | | | | |
| **Y  N** | Patient is unsuitable for telephone triage. If so please give reasons; | | | | | | | | | |

*Please ensure that you complete this section when you make a referral to the Digestive Hub – the information you provide us on this form will help the consultant make an informed decision on the patient’s care.*

|  |  |  |  |
| --- | --- | --- | --- |
| **Primary symptom:** | | | |
| |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | |  | Abdominal Pain |  | Change in Bowel Habit |  | Anaemia | | |  | Dysphagia |  | Known IBD |  | Abdominal Bloating/Gas | | |  | Dyspepsia/ GORD |  | Weight Loss |  | Nausea/Vomiting | | |  | Diarrhoea |  | Family history symptomatic |  |  | | |  | Constipation |  | Family history asymptomatic |  |  | | |  | Hernia |  | Rectal bleeding | | | | | | |
| **Other – please specify:** | | | |
| **Secondary symptom(s):** | | | |
| |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | |  | Abdominal Pain |  | Change in Bowel Habit | |  | Anaemia | | |  | Dysphagia |  | Weight Loss | |  | Nausea/Vomiting | | |  | Dyspepsia/ GORD |  | Abdominal Bloating/Gas | |  |  | | |  | Diarrhoea | Rectalbleeding | |  | | | |  | Constipation |  | Anorectal symptoms | |  |  | | | | | |
| **Other – please specify:** | | | |
| **Clinical Question:** | | | |
|  | | | |
| *History:* | | | |
| **Reason for referral/ desired outcome (More than one option may be selected):** | | | |
| |  |  |  |  | | --- | --- | --- | --- | |  | Patient request referral |  | Consultation (Face-to-Face) | |  | Failed treatment |  | Consultation (Telephone)  ?diagnosis and management letter | |  | Follow-up of chronic disease |  | Specific investigation (please specify below) | |  | Diagnosis & management |  | Other (please specify below) | |  |  |  |  |   **Consider Advice & Guidance** | | | |
| **Other – please specify:** | | | |
| **Investigations requested by GP (please see CAS pathway)** | | | |
| |  |  |  |  | | --- | --- | --- | --- | |  | FBC |  | Coeliac serology | |  | U&E |  | TFTs | |  | LFT |  | Faecal Calprotectin | |  | Bone profile |  | Abdominal ultrasound | |  | CRP |  | Faecal H. pylori antigen | |  | FIT |  | CA125 test | | | | |
| **FBC, UE, LFT** – please attach these tests results if they have been performed within the last **3 months**  **TFT, Coeliac serology and Bone profile** – please attach these test results if they have been performed within the last **12 months** | | | |
| **Other – please specify:** | | | |
| **Previous investigations** | | | |
| |  |  |  | | --- | --- | --- | |  | **Procedure:** | **Date:** | |  | Gastroscopy |  | |  | Flexible Sigmoidoscopy |  | |  | Colonoscopy |  | |  | ERCP |  | |  | MRI |  | |  | CT |  | |  | Ultrasound |  | | | | |
| **Please attach these results if they have not been performed at St George’s Hospital** | | | |
| **Patient History** | | | |
| Patient weight (kg): | Patient height (cm): | | Patient BMI: |
| **Drug History** | | | |
|  | | | |
| **GP details** | | | |
| GP Name: Usual GP Full Name | | Telephone Number: Usual GP Phone Number | |
| Practice: Usual GP Full Address (single line) | | Fax Number: | |
| Date of Referral: Short date letter merged | |