|  |  |
| --- | --- |
| Date Decision to Refer: | Referred By: |

|  |  |  |  |
| --- | --- | --- | --- |
| Name: | | DOB: | |
| Address: | | NHS Number: | |
| Hospital Number: | |
| Home Tel Number: | | Mobile Tel Number: | |
| Next of Kin or Carer details:  Name:  Contact number: | | Sex assigned at birth:  Gender Identity (if different from above): | |
| Ethnicity: | | Translator Required: Yes 🞏 No 🞏  Language: | |
| Disability: Yes 🞏 No 🞏  Please provide details: | | Capacity concerns: Yes 🞏 No 🞏  Please provide details: | |
| Registered GP Name: | | GP Practice Name: | |
| Surgery Contact Number: | | Surgery Address: | |
| Surgery Bypass Number: | | GP email address: | |
| Military Service Person 🞏 | Member of Military Family 🞏 | | Military Veteran 🞏 |

|  |  |
| --- | --- |
| Has the patient been informed of suspected cancer referral? | Yes 🞏 No 🞏 |
| Has the patient has received suspected cancer referral leaflet? | Yes 🞏 No 🞏 |
| Please confirm you have performed a physical exam, inc. a digital rectal exam on this patient prior to referral. If not, why not? | Yes 🞏 No 🞏 |
| Has the patient had previous gastrointestinal investigations in the last 2 years?  If yes, please specify what investigation and relevant findings: | Yes 🞏 No 🞏  Colonoscopy 🞏  Flexi Sigmoidoscopy 🞏  CT Colonography 🞏  OGD 🞏 |
| If your patient is found to have cancer, do you have any information which might be useful regarding their likely reaction to the diagnosis?  (e.g., a history of depression or anxiety, or a recent bereavement from cancer might be relevant) or their physical, psychological, or emotional readiness for further investigation and treatment? | Yes 🞏 No 🞏  Please provide details: |
| Date(s) that patient is unable to attend within the next two weeks? | Please provide details: |

|  |  |
| --- | --- |
| **Iron deficiency anaemia is confirmed if both Hb <120 (female); Hb <130 (male), MCV <80 and low ferritin or low transferrin saturation. If ferritin is normal & suspicion of IDA (ferritin unreliable in chronic kidney disease and inflammatory conditions) then check Transferrin saturation.**  **Please ensure bloods for ferritin or iron studies are taken before starting on oral iron.**  **If patient has blood loss or symptoms of gastro-intestinal disease, please investigate as appropriate to their presentation (this pathway is not appropriate). If patient does not fulfil the criteria for iron deficiency anaemia, consider referral to the Non-specific symptoms pathway (NSS) or Haematology instead.** | |
| **Criteria for referral to the iron deficiency anaemia service:** | |
| Bloods which confirm IDA as per guidance above? | Yes 🞏 No 🞏 |
| Urine dipstick done which is NEGATIVE for microscopic haematuria? | Yes 🞏 No 🞏 |
| If the patient a menstruating female, please confirm there has been NO heavy menstruation in the last 3 months. | Yes 🞏 No 🞏 |
| Have you ensured the patient is not pregnant? | Yes 🞏 No 🞏 Not applicable 🞏 |
| Prescribed oral iron replacement unless contraindicated? | Yes 🞏 No 🞏 |
| Has the patient previously been investigation for IDA? | Yes 🞏 No 🞏 If yes, please give details - |
| **Clinical details**  Please detail your conclusions and what needs to be excluded or attach a referral letter. Please also include your physical examination findings including rectal examination. *(This will allow patients to follow a straight to test pathway).* | |

|  |  |
| --- | --- |
| Is the patient on Anticoagulants or Antiplatelet agents? | Yes 🞏 No 🞏 |
| Is the patient on any ACEi/ARB? | Yes 🞏 No 🞏 |
| Is the patient on any diuretics? | Yes 🞏 No 🞏 |
| Is the patient on any NSAIDs? | Yes 🞏 No 🞏 |
| Is the patient on Lithium? | Yes 🞏 No 🞏 |
| Safe to stop **all** the above medication for 72hrs? | Yes 🞏 No 🞏 |
| Are you aware of the patient having an allergy to iodine/contrast medium (e.g. Gastrograffin, Primovist)? | Yes 🞏 No 🞏 |
| Is the patient fit for bowel preparation/endoscopy and willing to undergo this type of procedure? | Yes 🞏 No 🞏 |

**WHO Performance Status:**

|  |  |
| --- | --- |
| 0 ☐ | Fully active |
| 1 ☐ | Restricted in physically strenuous activity but ambulatory and able to carry out light work |
| 2 ☐ | Ambulatory and capable of self-care, unable to carry out work activities, up & about 50% of waking hours |
| 3 ☐ | Capable of only limited self-care, confined to bed/chair 50% of waking hours |
| 4 ☐ | No self-care, confined to bed/chair 100% |

|  |  |
| --- | --- |
| Significant Family History of GI and/or liver disease | Yes 🞏 No 🞏  Please provide details: |
| Significant Medical History (including cancer history) | *Auto populate from GP record* |
| Regular Medication | *Auto populate from GP record* |
| Allergies | *Auto populate from GP record* |
| Alcohol Intake | *Auto populate from GP record* |
| Smoking Status | *Auto populate from GP record* |
| Height, Weight, and BMI | *Auto populate from GP record* |

|  |  |
| --- | --- |
| **Please ensure bloods are dated within 4 -6 weeks of referral date** | |
| FIT test result |  |
| FBC | *Auto populate from GP record* |
| U&E’s | *Auto populate from GP record* |
| LFT’s | *Auto populate from GP record* |
| Iron Studies | *Auto populate from GP record* |
| TTG/Coeliac Screen | *Auto populate from GP record* |
| Clotting | *Auto populate from GP record* |
| GP has reviewed all results | Yes 🞏 No 🞏 |