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| Date Decision to Refer:  | Referred By:  |

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| 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 🞏  |

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| 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: |

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| **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).* |

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| 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:**

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|  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% |

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| 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* |

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| **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 🞏  |