**UPPER GI ENDOSCOPY**

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| **\*To:** |  **Referral Date:** **<Today's date>** |
| **\*Specialty:**       | **\*Sub Specialty** (*if appropriate)*:       |
| **\*Provider Booking Department** (*Insert provider organisation*):       |

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| **Patient Details** | **GP Details** |
| **Forename:** | <Patient Name> | **Referring GP:**  | <GP Name> |
| **Surname:** | <Patient Name> | **Registered GP:** | <GP Name> |
| **Date of Birth:** | <Date of birth> | **Practice:** | <Organisation Details><Organisation Address> |
| **NHS No:** | <NHS number> |
| **Gender:** | <Gender> |
| **Ethnicity:** | <Ethnicity> |
| **Hosp No** (if known)**:** |       |
| **Address:** | <Patient Address> |
| **Telephone:** | <Organisation Details> |
| **Fax:** | <Organisation Details> |
| **Practice code:** | <Organisation Details> |
| **Home Tel No:** <Patient Contact Details>**Work Tel No:** <Patient Contact Details>**Mobile Tel No:** <Patient Contact Details> |

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| **CLINICAL THRESHOLD - Upper GI Endoscopy** |
| Instructions for use: Please refer to policy for full details. Primary Care clinicians need to complete the checklist and submit with referral via eRS Secondary Care complete the checklist below and file for future compliance audit.The CCG will only fund upper GI Endoscopy when the following criteria are met\*:**For the investigation of symptoms c**linicians should consider endoscopy:* Any age with gastro-oesophageal symptoms that are nonresponsive to treatment or unexplained
* With suspected GORD who are thinking about surgery
* With H pylori that has not responded to second- line eradication
* Eradication can be confirmed with a urea breath test.

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| **Upper Endoscopy should only be performed if the patient meets one of the following criteria:** | **Tick as appropriate** |
| **Urgent: (Within two weeks**) Any dysphagia (difficulty in swallowing), to prioritise urgent assessmentof dysphagia please refer to the Edinburgh Dysphagia Score **OR** | Yes[ ]  | No[ ]  |
| **Aged 55 and over with weight loss and any of the following:**— Upper abdominal pain— Reflux— Dyspepsia (4 weeks of upper abdominal pain or discomfort— Heartburn— Nausea or vomiting | Yes[ ]  | No[ ]  |
| **Those aged 55 or over who have one or more of the following:**— Treatment resistant dyspepsia (as above), upper abdominal pain with low haemoglobin level (blood level) **OR**— Raised platelet count with any of the following: nausea, vomiting, weight loss, reflux, dyspepsia, upper abdominal pain **OR**— Nausea and vomiting with any of the following: weight loss, reflux, dyspepsia, upper abdominal pain. | Yes[ ]  | No[ ]  |
| **For the assessment of Upper GI bleeding:**— For patients with haematemesis, calculate Glasgow Blatchford Score atpresentation and any high-risk patients should be referred— Endoscopy should be performed for unstable patients with severe acuteupper gastrointestinal bleeding immediately after resuscitation— Endoscopy should be performed within 24 hours of admission for all otherpatients with upper gastrointestinal bleeding. | Yes[ ]  | No[ ]  |
| **For the investigation of symptoms:**— Clinicians should consider endoscopy:— Any age with gastro-oesophageal symptoms that are nonresponsiveto treatment or unexplained— With suspected GORD who are thinking about surgery— With H pylori that has not responded to second- line eradicationEradication can be confirmed with a urea breath test. | Yes[ ]  | No[ ]  |
| **For the management of specific cases** |
| **For H pylori and associated peptic ulcer:**Eradication can be confirmed with a urea breath test, however if peptic ulcer is present repeat endoscopy should be considered 6-8 weeks after beginning treatment for H pylori and the associated peptic ulcer | Yes[ ]  | No[ ]  |
| **For Barrett’s oesophagus:*** The non-endoscopic test called Cytosponge can be used (where available) to identify those who have developed Barrett’s oesophagus as a complication of long-term reflux and thus require long term surveillance for cancer risk
* Consider endoscopy to diagnose Barrett’s Oesophagus if the person has GORD (endoscopically determined oesphagitis or endoscopy – negative reflux disease)

Consider endoscopy surveillance if person is diagnosed with Barrett’s Oesophagus. | Yes[ ]  | No[ ]  |
| **For coeliac disease**:Patients aged 55 and under with suspected coeliac disease and anti-TTG >10x reference range should be treated for coeliac disease on the basis of positive serology and without endoscopy or biopsy. | Yes[ ]  | No[ ]  |
| **Surveillance endoscopy:*** Surveillance endoscopy should only be offered in patients fit enough for subsequent endoscopic or surgical intervention, should neoplasia be found. Many of this patient group are elderly and/or have significant comorbidities. Senior clinician input is required before embarking on long term endoscopic surveillance
* Patients diagnosed with extensive gastric atrophy (GA) or gastric intestinal metaplasia, (GIM) (defined as affecting the antrum and the body) should have endoscopy surveillance every three years

Patients diagnosed with GA or GIM just in the antrum with additional risk factors- such as strong family history of gastric cancer of persistent Hpylori infection, should undergo endoscopy every three years. | Yes[ ]  | No[ ]  |
| **Screening endoscopy can be considered in:*** European guidelines (2015) for patients with genetic risk factors / family history of gastric cancer recommend genetics referral first before embarking on long term screening. Screening is not appropriate for all patients and should be performed in keeping with European expert guidelines
* Patients where screening is appropriate, for individuals aged 50 and over, with multiple risk factors for gastric cancer (e.g. H. Pylori infection, family history of gastric cancer - particularly in first degree relative -, pernicious anaemia, male, smokers).
 | Yes[ ]  | No[ ]  |
| **Post excision of adenoma:*** Following complete endoscopic excision of adenomas, gastroscopy should be performed at 12 months and then annually thereafter when appropriate.
 | Yes[ ]  | No[ ]  |

*\* If clinician considers need for referral/treatment on clinical grounds outside of these criteria, please refer to the individual funding requests policy for further information. If patient meets the above criteria then prior approval is not required.* Endoscopy should be offered only as recommended in guidance from NICE and the British Society for Gastroenterology which are incorporated in the guidance.NICE guideline on coeliac disease: recognition, assessment and management | The British Society of Gastroenterology (bsg.org.uk)\*Glasgow-Blatchford Bleeding Score (GBS) - MDCalc |

**PLEASE NOTE:** Secondary Care to reject referral if this form is not complete and return patient to Primary Care.

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| Dear Colleague, Thank you for kindly seeing this patient.**Presenting Complaint**     **Relevant Clinical Findings**     **Action to be Taken**     I have attached my recent consultation herewith which is also self-explanatory. I will appreciate your assessment and advice. Many thanks.<GP Name> |

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| **\*Interpreter required?** **[ ]** Yes/[ ]  No**.** **If yes, please state which language:**       |

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| **MEDICAL HISTORY*** **History**

Active Problems<Problems(table)>Significant Past<Problems(table)>* **Last Consultation/s**

<Event Details(table)>* **Current medication:**

Acute<Medication(table)>Repeat<Medication(table)>* **Blood Pressure:**

<Last 5 BP Reading(s)(table)>* **Alcohol Consumption**

<Numerics>* **Current allergies**

<Allergies & Sensitivities(table)> |

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| **LABORATORY RESULTS (Latest result within last year unless stated)**Lipids**Glucose / HbA1c**Liver Function TestsRenal / Prostate FunctionHaematologyThyroid FunctionUrinalysisPeak Flow**Histology / ECG / Radiology (Last 2 years)**  |