Patient Name: Address: Date of Birth: NHS Number Consultant/Service to whom referral will be made:

Please send this form with the referral letter.

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 SY ICB will only fund upper GI Endoscopy when the following criteria are met*:

For the investigation of symptoms clinicians 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.

Upper Endoscopy should only be performed if the patient meets one of the following criteria:	**Delete as appropriate**	
Urgent: (Within two weeks) Any dysphagia (difficulty in swallowing), to prioritise urgent assessment of 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 at presentation and any high-risk patients should be referred — Endoscopy should be performed for unstable patients with severe acute upper gastrointestinal bleeding immediately after resuscitation	Yes	No

— Endoscopy should be performed within 24 hours of admission for all other patients with upper gastrointestinal bleeding.		
For the investigation of symptoms: — Clinicians 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.	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	Yes	No

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).		
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