

URGENT

ROUTINE

MR/ MRS/ MISS	DATE OF BIRTH:
SURNAME:	REFERRING GP:
FIRST NAME(S):	REGISTERED GP:
NHS NUMBER:	GMC CODE:
GENDER:	PRACTICE CODE:
ETHNICITY:	PRACTICE ADDRESS:
ADDRESS:	
POSTCODE:	TEL NO:
HOME TEL NO:	FAX NO:

Rectal Bleeding Yes

Duration of symptoms weeks mthsyrs

Any other GI symptoms

Relevant Past Medical History:-

.....

Current Medication:-

Allergies:-

*** PATIENTS WITH THE FOLLOWING ARE NOT SUITABLE FOR OPEN ACCESS SIGMOIDOSCOPY AND SHOULD BE REFERRED TO A GASTROENTEROLOGIST**

- Moderate/Severe Cardiac Failure
- Moderate/Severe Renal Failure
- Anticoagulated Patients
- Patients unable to self administer a rectal enema.

Signature of GP

Date.....