KINGS BRIDGE *Private Hospital*

★★★★★

DIAGNOSTIC & TREATMENT CENTRE

Request for Endoscopy

Patient ID Number:	

Referrers are required to complete sections accurately and legibly. Inadequately completed forms will not be accepted.

Please send completed form via email to **endoscopy@kingsbridgehealthcaregroup.com**

PATIENT DETAILS

Title:		**Forename:**		**Surname:**	
DOB:		**Gender:**	**Male** ☐ **Female** ☐		
Address:					
Postcode:		**Tel (Home):**		**Mobile:**	

PATIENT IDENTIFICATION (For Kingsbridge Private Hospital use only)

I have confirmed the above patient's name, address and DOB. Signed:

Verified by patient ☐ **If another/status:** **Signed:**

REFERRER DETAILS

Referring Clinician:		**Signature:**		**Date:**	
Address:				**Postcode:**	
Email:		**Tel:**			

REFERRAL TYPE

Red Flag ☐ **Urgent** ☐ **Routine** ☐

Endoscopy procedure required:

Clinical indication for procedure:

Additional clinical history:

Continued >

KINGS BRIDGE Private Hospital
★★★★★
DIAGNOSTIC & TREATMENT CENTRE

Request for Endoscopy

Is patient on blood thinners: Yes ☐ **No** ☐		
If yes, which blood thinner and dose:		
Is patient diabetic: Yes ☐ **No** ☐	**Allergies:**	
eGFR (must be within the last 3 months):	**ml/min**	**Date taken:**

For Kingsbridge Private Hospital admin use:	
The patient is: Insured ☐ **Self funding** ☐ **WLI** ☐ **Employer** ☐ **Occ Health/Screen** ☐	
Insurance Company/Trust:	
Policy number:	**Authorisation number:**

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