

Referral Form for Direct access Endoscopy

Please complete and return to:

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Your Details:

Name:	
Address:	
Post Code:	
Male/Female:	
Date of Birth:	
Telephone:	
E-mail:	

Your Doctors Details:

Date Referred:	
Name of your GP:	
GP Address:	
Post Code:	
Telephone:	

Clinical Details (please tick all applicable boxes):

Symptoms

Acid reflux Dyspepsia Nausea Vomiting Weight loss

Medical History:

Known Barrett's oesophagus Previous stomach ulcer Significant heart problems
 Diabetes (Tablet controlled, Insulin or both) Significant respiratory problems Artificial heart valve
 Chronic kidney problems Warfarin Clopidogrel Dabigatran

Results of previous tests (please attach results if available):

Past endoscopy Iron deficiency Abnormal liver function tests Scan results

Any Additional Information:

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