# SJH Interventional Endoscopy Referral Form

* Please complete all sections of the attached referral form.
* If you are unsure or unable to complete the form, please contact the ERCP phone on 0874644573 or email ercp@stjames.ie to discuss your referral.
* Once complete, please attach all relevant imaging and blood reports and this form in a single electronic document and email to ercp@stjames.ie

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| Patient Details (Hospital Stickers are acceptable) |
| Patient Name |  |
| Patient DOB |  |
| Patient Address |  |
| Patient Contact Mobile Number |  |
| Referring Service Details |
| Date of Referral |  |
| Referring Consultant |  |
| Referring Hospital & Current Ward |  |
| Nominated NCHD Contact Names (2 required) |  |  |
| NCHD Contact Mobile Number (2 required)Bleeps are NOT accepted |  |  |
| Clinical Details |
| Indication for Request |  |
| Imaging Completed*Tick as Appropriate* | US | Date: | Report Attached:  |
| CT | Date: | Report Attached:  |
| MRCP/MRI | Date: | Report Attached:  |
| Blood Results*All bloods are required. Please include a copy of all lab results with referrals.* | Date of Blood Results: |
| Hb | Plts | INR | Cr |
| Bili | Alk P | GGT | ALT |
| Pregnancy Status | All female patients aged <55 are required to have a confirmed negative urine or serum β-HCG. |
| Date: | Result: |
| Previous ERCPs or Upper GI Surgery | Has this patient undergone any previous ERCPs or Upper GI surgery?If yes, please provide dates and locations of previous intervention. |
| Yes: | No: |
| Details: |
| Patient Medications |
| Is the patient taking any Antiplatelets?*E.g. Aspirin, Clopidogrel, Ticagrelor* | Drug Name:Dose:Last date taken: | No: |
| Is the patient taking any Anticoagulation?*E.g. Apixaban, Rivaroxaban, Warfarin, Enoxaparin* | Drug Name:Dose:Last date taken: | No: |
| Is the patient currently on any Antibiotics? | Drug Name:Dose:Last date taken: | No: |
| Informed Consent Process |
| **Interventional Endoscopy (e.g. ERCP) carries a small but significant risk to patient health. Referring clinicians are required to discuss the risks and benefits of procedures with both the patient and any family members PRIOR to a referral for a procedure. By completing this form, you must acknowledge that this discussion has taken place.** |
| Have the patient (and NOK) been informed of the request for an interventional procedure? | Yes:Date: | NCHD Signature: |
| Has the Patient signed the consent form attached to this referral? | Yes:Date: | NCHD Signature: |
| Safe Transfer Checklist |
| **Please ensure all of the following are included with the patient to ensure a safe hospital transfer.** Please tick to acknowledge each: |
| **Transfer Requirements** | **Included/Acknowledged:** | **Details:** |
| Referral Letter |  |  |
| Patient Fasting(Minimum 8 hours pre procedure) |  |  |
| IV Cannula in Right Arm |  |  |
| Imaging Reports |  |  |
| Blood Results |  |  |
| Covid-19 Status(Swab Date and Result) |  |  |
| Medication List/Inpatient Kardex |  |  |
| Confirmed Return Ambulance Transfer |  | Company Name: |
| Signed Consent Form |  |  |



