# 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 |  | | |  | | |

A medical information on the front of a patient's body

Description automatically generated with medium confidence

A group of papers with text

Description automatically generated