Direct Access Endoscopy Referral Form

REFERRALS TO:
T: 02 4306 3000 F: 02 4302 0846
E: referrals@gosforddayhospital.au
W: www.gosforddayhospital.au

PATIENT DETAILS:

Name: .....

Date of Birth: ..... Sex: .....

Address: .....

Suburb: ..... Postcode: .....

Email: .....

Phone (Home): .....

Mobile: .....

Private Health Fund: .....

Medicare No: .....

REFERRING DOCTORS DETAILS:

Name: .....

Practice: .....

Practice Address: .....

Suburb: ..... Postcode: .....

Phone: ..... Fax: .....

Email: .....

Provider number: .....

Date: .....

Signature: .....

Indications for open access:

☐ FOBT +ve ..... National bowel screening: Yes ☐ No ☐ Other: .....

☐ PR Bleeding: .....

☐ Iron deficiency anemia: .....

☐ Suspected malignancy with alarming symptoms: .....

☐ Family history of colorectal cancer: .....

☐ History of colonic polyps and others: .....

Patient Background

Are they on any blood thinners/ Anticoagulants?
eg Aspirin, Plavix, Warfarin, Pradaxa, Eliquis , Xarelta , fish oil etc .....

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☐ Heart conditions: .....

☐ Diabetes: .....

☐ Kidney disease: .....

☐ Liver disease: .....

☐ Allergies: .....

☐ Medications: .....

☐ Anaesthetic risks: .....

☐ Weight: .....

On receiving the form, we will contact the patient. Please email referral to referrals@gosforddayhospital.au