ENDOSCOPY SERVICES REFERRAL FORM

Dalley Street
LISMORE NSW 2480
Telephone: 02 6627 9266
Facsimile: 02 6627 9268

PATIENT DETAILS

Surname .....

Given Names .....

Date of Birth ..... Age .....

Phone Number (Home) ..... (Work) .....

PAST MEDICAL HISTORY and CURRENT MEDICATIONS

- ***Please attach a current health summary and any relevant pathology with this referral***

Patients with any of the following indicators may not be suitable for open access and will be reviewed for suitability by a Gastroenterologist (please tick all that apply)

- ❒ **Age > 80**
- ❒ **BMI > 40**
- ❒ **CVA/TIA within 3 months**
- ❒ **Acutely ill / febrile**
- ❒ **Chronic Renal Failure**
- ❒ **AMI within 3 months**
- ❒ **Diabetic**
- ❒ **Severe Asthma / CAL**
- ❒ **Takes antiplatelets/NOACs**
- ❒ **Cardiac/vascular stents inserted in the last 12 months**
- ❒ **Unstable angina**
- ❒ **Confusion / Dementia**
- ❒ **Intending overseas travel within 2 weeks**

REQUEST

❒ Upper Gastrointestinal Endoscopy ❒ Colonoscopy

PREFERRED GASTROENTEROLOGIST

❒ Dr M Cornwell ❒ Dr H Hope ❒ Dr I Singh-Grewal ❒ or first available

❒ Dr D Whitaker ❒ Dr A Thomson ❒ Dr H Aghdaei

INDICATION: Symptoms, signs and/or investigation findings prompting referral

❒ Positive FOB ❒ National Bowel Cancer Screening Program ❒ Unexplained weight loss

❒ Rectal bleeding, duration _____ weeks ❒ Anaemia ❒ Fe Deficiency

❒ Diarrhoea (stool culture negative), duration _____weeks

❒ Unexplained abdominal pain >6 weeks ❒ Palpable mass - ❒ Abdominal ❒ Rectal

❒ Family history ❒ Past polyps ❒ Past cancer ❒ Reflux ❒ Dysphagia

❒ Other .....

Date of last colonoscopy ____/____/____ (provide a copy of results if not performed at St Vincent's)

REFERRING DOCTOR

Print Name ..... Signature .....

Date ..... Provider No. .....

Referring Practice .....

BINDIGN MARGIN – DO NOT WRITE

ENDOSCOPY SERVICES REFERRAL FORM