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| OPEN ACCESS REFERRAL FORM FOR* GASTROSCOPY ☐ COLONOSCOPY

(Please tick procedure) | SURNAME Click or tap here to enter text. PH: GIVEN NAME Click or tap here to enter text.DOB Click or tap to enter a date. SEX: ☐ Male ☐ Female*AFFIX PATIENT INDETIFICATION LABEL HERE* |

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| **DOCTOR**(Please tick surgeon) | * Dr Abraham ☐ Dr Das ☐ Dr Petrushnko ☐ Dr Ramsay ☐ Dr Roussos
* Dr Salindera ☐ Dr Su ☐ Dr Sutherland ☐ Dr Wenman
 |
| **FACILITY**(Please tick facility) | * Baringa Private Hospital
 | * Ramsay Surgical Centre Coffs Harbour
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| **PROCEDURE DETAILS**(Please tick procedure) |
| **Indications for Colonoscopy** | **Indications for Gastroscopy** |
| Rectal Bleeding |  |  |  | Dyspepsia |  |  |
| Change in bowel habit |  |  |  | Gastro-esophageal reflux |  |
| Constipation |  |  |  | Upper abdominal pain |  |
| Diarrhoea |  |  |  | Dysphagia (please do Barium Swallow first) |  |
| Lower abdominal pain |  |  |  | Iron deficiency |  |  |
| Previous colorectal cancer/polyps |  |  | Other (please specify):………………………………............................................. |
| Family history of colorectal cancer |  |  | **Other Details** |
| Positive faecal occult blood test |  |  | **Patients Height** | Click or tap here to enter text. |
| Iron deficiency |  |  |  | **Patients Weight** | Click or tap here to enter text. |
| Abnormality on barium enema |  |  | **BMI** | Click or tap here to enter text. |
| Other (please specify):Click or tap here to enter text. | **Patient over 50 years of age?** | * Yes ☐ No
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| **PATIENT MEDICAL DETAILS** |
| Is patient diabetic? | * Yes
 | * No
 | If yes, is patient taking insulin? | * Yes
 | * No
 |
| Is patient on Anticoagulant Drugs? | * Yes
 | * No
 | If yes, can it be stopped? | * Yes
 | * No
 |
| Is patient on Antiplatelet Drugs? | * Yes
 | * No
 | If yes, can it be stopped? | * Yes
 | * No
 |
| Does patient have sleep apnoea? | * Yes
 | * No
 | If yes, does the patient require CPAP? | * Yes
 | * No
 |
| Does patient have any allergies? | * Yes
 | * No
 | If yes, please specify:Click or tap here to enter text. |
| This patient has no major cardiovascular or respiratory problems which may contraindicate intravenous sedation/general anaesthesia - If in doubt, please arrange a routine referral to the rooms. | * Yes
 | □ No |

Please attach a GP health summary including current medications and return this form to endoscopist’s rooms

Name: Click or tap here to enter text. Provider No: Click or tap here to enter text.

Signature: Click or tap here to enter text. Date: Click or tap to enter a date.

**THIS DOCUMENT IS CONTROLLED**

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