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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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