AlfredHealth

☐ Alfred ☐ Sandringham ☐ Caulfield

Unit:……………………………….

UR:

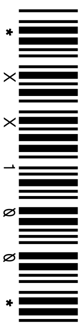
Family Name

Given Names

Date of Birth

Gender: ☐ Male ☐ Female

# PEG CLINIC REFERRAL



GP Name:

GP Address

GP Phone: GP Fax:

Interpreter required ☐ Yes ☐ No If yes, Language

## Medical Diagnosis (Relating to tube insertion)

## Relevant History

## Enteral Feeding Tube Details

**Initial Insertion Date:** ….. / ….. / …..

**Initial Insertion Location** ☐ Alfred Endoscopy ☐ Alfred Radiology ☐ Alfred Surgery ☐ Cabrini ☐ Other (specify) ______

**Date of most recent change:** ….. / ….. / …..

**TUBE TYPE** ☐ Gastrostomy (☐ Low Profile) ☐ Jejunostomy ☐ Other ______

**BRAND** ☐ Bard ☐ Cook ☐ Covidien ☐ Kimberly Clark ☐ Other ______

**FRENCH** ☐ 16 ☐ 18 ☐ 20 ☐ Other ______

**REMOVAL METHOD** ☐ External Traction ☐ Endoscopic Removal ☐ Unknown ☐ Balloon ☐ Obturator Removal

**Position of external marker at skin level OR shaft length (cm)** ______

## Reason for Review

☐ Initial Consultation ☐ Tube / Stoma Problems
☐ Tube Replacement/Removal ☐ Other ______

**For Alfred Tube Insertion**
Phone The Alfred Gastroenterology Dept on X 65487 for an appointment
Appointment Details:
Thursday ___ / ___ / ___ Time: ___ : ___
Then fax the completed form to X 62194

**For Non-Alfred Tube Insertion**
Fax this form AND a referral letter from the patient's GP or appropriate medical specialist to The Alfred, Gastroenterology Dept, Fax 03 9076 2194
PH 03 9076 5487

Referral sent by:
Print Name: ______ Designation ______

Signature: ______ Date: ___/___/___ Ph: ______



Date Created: Oct 2015
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Scanned to: Referrals

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