AlfredHealth

UR

☐ Alfred ☐ Sandringham ☐ Caulfield

REFERRAL FOR GASTROINTESTINAL ENDOSCOPY

- Attach any current reports and investigations
- Your patient will be contacted with appointment details

Enquiries Dept of Gastroenterology T 9076 0213
Send referral to F 9076 6938 E op.referrals@alfred.org.au
Postal address Dept of Gastroenterology, Alfred Centre
Ground Floor, 99 Commercial Road, Melbourne, VIC, 3004

Patient details

*mandatory fields

Last name*		First name*		Date of birth*	
Sex at birth	☐ Female ☐ Male ☐ Other	Gender identity	☐ Female ☐ Male ☐ Non binary ☐ Not stated ☐ Prefer not to answer ☐ Different term		
Address*					
Telephone*		Medicare No		Ref / Exp	
☐ Bulk Bill ☐ Private ☐ DVA ☐ Other					
Interpreter ☐ Yes ☐ No		Language			
Aboriginal status	☐ Not Aboriginal or Torres Strait Islander ☐ Torres Strait Islander not Aboriginal ☐ Aboriginal not Torres Strait Islander	☐ Aboriginal and Torres Strait Islander ☐ Prefer not to answer ☐ Not specified			
Cultural / support needs					
Contact person name		Relationship		Telephone	

☐ Gastroscopy

☐ Bleeding ☐ Haematemesis / malaena
☐ Iron deficient anaemia *(attach FBE / Fe studies)*
☐ Dysphagia ☐ Loss of Weight
☐ Abnormal imaging *(attach report)*
☐ Pain ☐ Dyspepsia
☐ Reflux ☐ Atypical chest pain
☐ Nausea / vomiting / loss of appetite
☐ Barrett's screening
☐ Small bowel biopsy – coeliac screening
☐ Varices: possible therapy
☐ Other *(list))*

☐ Colonoscopy or ☐ Flexible Sigmoidoscopy

☐ PR Bleeding ☐ Bright ☐ Dark / mixed ☐ FOBT ☐ NBCSP
Duration _____
☐ Iron Deficient Anaemia (attach FBE / Fe studies)
☐ Altered bowel habit ☐ Diarrhoea
☐ Constipation: Duration _____
☐ Known large polyp *(attach report)*
☐ Abnormal imaging *(attach report)*
☐ Surveillance ☐ Previous Ca ☐ Previous polyps
☐ Family history Ca *(list below)* ☐ IBD
☐ Weight Loss % of body weight lost _____ Duration _____
☐ Other *(list))*

Inpatient / Complex / Therapeutic Referrals

Discussed with ☐ Gastro Reg ☐ Consultant_____

☐ PEG ☐ ERCP ☐ Endoscopic ultrasound ☐ Balloon Enteroscopy ☐ Antegrade ☐ Retrograde

Details

Anti Coag / Anti Platelet Therapy		**Comordibities** *(must be completed)*	
☐ None	Can it be stopped?	☐ None	☐ Diabetes: ☐ Type 1 ☐ Type 2
☐ DOACs	☐ Yes ☐ No	☐ Cardiac	☐ Vancomycin Resistant Enterococci
☐ Clopidogrel	☐ Yes ☐ No	☐ Respiratory	☐ Blood Borne Virus *(detail)*
☐ Warfarin	☐ Yes ☐ No	☐ Renal	
☐ Other	☐ Yes ☐ No		

Allergies ☐ Nil known ☐ Yes, *list*

Comments

Referrer details	Date of referral		Provider No	
Name		Address		
Telephone		Fax	Email	
Copies to				

EMR: Referrals / Referral to Gastro Diagnostics

MR
R29

Sept 2024
Source: www.alfredhealth.org.au