

☐ Alfred ☐ Sandringham ☐ Caulfield

REFERRAL FOR GASTROINTESTINAL ENDOSCOPY

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|--|---|
| <ul style="list-style-type: none"> 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 | |
| Family Name* | Given Name* |
| Date of Birth* | Sex <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Other |
| Address* | |
| Telephone* | Medicare No 8888 88888 Ref |
| <input type="checkbox"/> Bulk Bill <input type="checkbox"/> Private <input type="checkbox"/> DVA <input type="checkbox"/> Other | |
| Interpreter | <input type="checkbox"/> Yes <input type="checkbox"/> No Language |
| Aboriginal or Torres Strait Islander | |
| Cultural considerations / support needs | |
| Contact Person | Name |
| | Relationship Telephone |
| <input type="checkbox"/> Gastroscopy <input type="checkbox"/> Colonoscopy or <input type="checkbox"/> Flexible Sigmoidoscopy | |
| <input type="checkbox"/> Bleeding <input type="checkbox"/> Haematemesis / malaena <input type="checkbox"/> Iron deficient anaemia (attach FBE / Fe studies) <input type="checkbox"/> Dysphagia <input type="checkbox"/> Loss of Weight <input type="checkbox"/> Abnormal imaging (attach report) <input type="checkbox"/> Pain <input type="checkbox"/> Dyspepsia <input type="checkbox"/> Reflux <input type="checkbox"/> Atypical chest pain <input type="checkbox"/> Nausea / vomiting / loss of appetite <input type="checkbox"/> Barrett's screening <input type="checkbox"/> Small bowel biopsy – coeliac screening <input type="checkbox"/> Varices: possible therapy <input type="checkbox"/> Other (list) | |
| <input type="checkbox"/> PR Bleeding <input type="checkbox"/> Bright <input type="checkbox"/> Dark / mixed <input type="checkbox"/> FIBT <input type="checkbox"/> NBCSP <input type="checkbox"/> Iron Deficient Anaemia (attach FBE / Fe studies) <input type="checkbox"/> Altered bowel habit <input type="checkbox"/> Diarrhoea <input type="checkbox"/> Constipation: Duration <input type="checkbox"/> Known large polyp (attach report) <input type="checkbox"/> Abnormal imaging (attach report) <input type="checkbox"/> Surveillance <input type="checkbox"/> Previous Ca <input type="checkbox"/> Previous polyps <input type="checkbox"/> Family history Ca (list below) <input type="checkbox"/> IBD <input type="checkbox"/> Weight Loss % of body weight lost <input type="checkbox"/> Other (list) | |
| Inpatient / Complex / Therapeutic Referrals Discussed with <input type="checkbox"/> Gastro Reg <input type="checkbox"/> Consultant | |
| <input type="checkbox"/> PEG <input type="checkbox"/> ERCP <input type="checkbox"/> Endoscopic ultrasound <input type="checkbox"/> Balloon Enteroscopy <input type="checkbox"/> Antegrade <input type="checkbox"/> Retrograde | |
| Details | |
| Anti Coag / Anti Platelet Therapy | |
| <input type="checkbox"/> None Can it be stopped? <input type="checkbox"/> DOACs <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Clopidogrel <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Warfarin <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Comorbidities (must be completed) | |
| <input type="checkbox"/> None <input type="checkbox"/> Cardiac <input type="checkbox"/> Respiratory <input type="checkbox"/> Renal <input type="checkbox"/> Diabetes: <input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2 <input type="checkbox"/> Vancomycin Resistant Enterococci <input type="checkbox"/> Blood Borne Virus (detail) | |
| Allergies <input type="checkbox"/> Nil known <input type="checkbox"/> Yes, list | |
| Comments | |
| Referrer Details | |
| Date of Referral | |
| Provider No | |
| Name | Address |
| Telephone | Fax Email |
| Copies to | |