

PATIENT DETAILS

Surname

Given Names

Date of Birth Age

Phone Number (Home) (Work)

REQUEST

Upper Gastrointestinal Endoscopy Colonoscopy

PREFERRED GASTROENTEROLOGIST

Dr M Cornwell Dr H Hope Dr I Singh-Grewal

Dr D Whitaker Dr A Thomson or first available

INDICATION *(PLEASE PROVIDE A PATIENT HEALTH SUMMARY WITH THIS REFERRAL)*

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Patients with any of the following indicators will not be suitable for open access and will require at least a telephone consultation with a Gastroenterologist:

- Age > 80
- BMI > 40
- CVA within 3 months
- Acutely ill / febrile
- AMI within 3 months
- Chronic Renal Failure
- Patients who have had drug eluting stents within the last 18 months
- Diabetic
- Severe Asthma / CAL
- TIA within 3 months
- Takes anticoagulants
- Takes clopidogrel
- Unstable angina
- Intending overseas travel within 2 weeks
- Confusion / Dementia

CURRENT MEDICATIONS

<i>Medication</i>	<i>Dosage</i>
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REFERRING DOCTOR

Print Name Signature.....

Date..... Provider No.....

BINDING MARGIN – DO NOT WRITE