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**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**

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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 > 75
- 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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.....	.....
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**REFERRING DOCTOR**

Print Name ..... Signature .....

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