|  |  |
| --- | --- |
| ***Direct Access Endoscopy/Colonoscopy***  **Referral Form**  Completed forms forwarded to Colorectal Specialist Group:  **Email:** admin@gisurgery.net.au  **Fax:** 08-8275 3197 | **Suite 209  Flinders Private Hospital,  Bedford Park, SA 5042**  **Suite 6, 19 Alexander Ave,  Ashford SA 5035**  Phone: 08-8371 3077  Fax: 08-8275 3197 |

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**PREFERRED SPECIALIST**

*(Patient will be booked onto the next available list; if ANY is ticked patient will be referred to earliest available list)*

|  |  |  |  |
| --- | --- | --- | --- |
|  | Dr Dayan DeFontgalland |  | Dr Tiong Cheng (TC) Sia |
|  | Dr Eu Nice Neo |  | Dr Abdullah Rana |
|  | Dr Janina Kaczmarczyk |  | Any surgeon |

**PATIENT DETAILS**

Patient Name: [Full Name] Sex: M / F

Address: [Address]

Postal Address (if different to above): [Postal Address]

DOB: DD/MM/YYYY Phone: [Phone] Mobile: [Mobile]

Private Health Insurance: Y / N Fund Name/Number: [Fund Name/Number]

DVA Gold Card Holder: Y / N Card/Fund Number: [Card/Fund Number]

Medicare Number: [Card Number]

**REQUESTED PROCEDURE**

|  |  |
| --- | --- |
|  | Endoscopy |
|  | Colonoscopy |
|  | Endoscopy and Colonoscopy |

**INDICATION**

Asymptomatic patients with *(please tick):*

|  |  |  |  |
| --- | --- | --- | --- |
|  | Positive Faecal Occult Blood test |  | Previous history of polyps requiring surveillance |
|  | Family history of bowel cancer |  | Iron deficiency anaemia (Endoscopy and Colonoscopy) |

*Clinical symptoms prompting colonoscopy, language barriers, consent difficulties and significant comorbidities will require initial specialist consultation prior to procedure. Direct access referrals can be independently discussed with our surgeons prior to procedure should the referring practitioner deem direct access appropriate.*

**PAST MEDICAL HISTORY**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **YES** | **NO** | **DETAILS** |
| Cardiac |  |  |  |
| Respiratory |  |  |  |
| Diabetes |  |  |  |
| Renal impairment |  |  |  |
| Cognitive status |  |  |  |
| MRSA/VRE |  |  |  |
| Other relevant |  |  |  |

**MEDICATIONS**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **YES** | **NO** | **DETAILS** |
| Warfarin |  |  |  |
| Clopidogrel |  |  |  |
| Oral Anticoagulation |  |  |  |
| Diabetic medication |  |  |  |
| Aspirin |  |  |  |
| Iron |  |  |  |
| Other relevant |  |  |  |

*SLGT2 inhibitor agents include Dapagliflozin (Forxiga®), Empagliflozin (Jardiance®), Canagliflozin (Invokana® - available in New Zealand but not in Australia), or a combination with metformin (Xigduo®, Jardiamet®) are to be ceased 3 days prior*

**ALLERGIES**

|  |
| --- |
|  |

**REFERRING DOCTOR**

Referring Doctor’s Name: [Referring Doctor’s Name]

Provider Number: [Provider Number]

Address: [Doctor’s Address]

Phone: [Doctor’s Phone] Fax: [Doctor’s Fax]

Signature: Date: DD/MM/YYYY