SPRINGWOOD DAY SURGERY

DIRECT ACCESS ENDOSCOPY PATIENT REFERRAL

GENERAL PRACTIONER DETAILS

Please complete this information for our team to keep you informed and follow up if necessary regarding your patient.

FIRST NAME:	LAST NAME:
PRACTICE NAME:	PROVIDER NO:
PRACTICE EMAIL:	
PERSONAL EMAIL:	MOBILE NO:

PATIENT DETAILS

Please complete this information, our team will contact your patient directly to organise a screening assessment, or consult with our clinical team.

FIRST NAME:	LAST NAME:
CONTACT NO:	DATE OF BIRTH:
PATIENT EMAIL:	

PROCEDURE REQUIRED

The patient will receive a brief consultation on the day with a participating specialist prior to their procedure.

- ☐ BOTH GASTROSCOPY & COLONOSCOPY
- ☐ COLONOSCOPY
- ☐ FLEXIBLE SIGMOIDOSCOPY
- ☐ GASTROSCOPY

INDICATION FOR REFERRAL FOR GASTROSCOPY

- ☐ ABDOMINAL BLOATING
- ☐ TEST FOR COELIAC DISEASE - LACTOSE INTOLERANCE
- ☐ OESOPHAGEAL REFLUX
- ☐ DIFFICULTY SWALLOWING
- ☐ ABDOMINAL PAIN
- ☐ SCREENING - FOLLOW UP
- ☐ IRON DEFICIENCY
- ☐ FAMILY HISTORY OF STOMACH CANCER
- ☐ WEIGHT LOSS
- ☐ OTHER (if other please provide details below)

OTHER DETAILS :

INDICATION FOR REFERRAL FOR COLONOSCOPY

- ☐ POSITIVE FOBT
- ☐ PR BLEEDING
- ☐ FAMILY HISTORY OF BOWEL CANCER - SCREENING
- ☐ CHANGE IN BOWEL FUNCTION
- ☐ ABDOMINAL PAIN
- ☐ PREVIOUS POLYP OR COLONIC CANCER
- ☐ FOLLOW UP
- ☐ SURVEILLANCE OF POLYP
- ☐ OTHER (if other please provide details below)

OTHER DETAILS :

CURRENT MEDICATIONS

ADVERSE DRUG REACTIONS

ADDITIONAL INFORMATION