

**DIRECT ACCESS ENDOSCOPY REFERRAL**

**PATIENT DETAILS**

Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Phone: \_\_\_\_\_  
 Mobile Phone: \_\_\_\_\_  
 DOB: \_\_\_\_\_  
 Medicare: \_\_\_\_\_  
 Health Fund:  YES  NO

**REFERRER DETAILS**

Name: \_\_\_\_\_  
 Practice Name and Address: \_\_\_\_\_  
 Provider Number: \_\_\_\_\_  
 Phone Number: \_\_\_\_\_  
 Email: \_\_\_\_\_  
 Date of Referral: \_\_\_\_\_

- Gastroscopy +/- intervention  
 Colonoscopy +/- intervention  
 Health Fund  Self Funded  Uninsured

Medical history:

Weight:

Height:

Cardiac History (stent, pacemaker, defibrillator):

Medications:

Anti-platelets, anti-coagulants, diabetic tablets or diabetic injectables?

**INDICATIONS**

**Gastroscopy**

- FH of stomach cancer
- Unexplained iron deficiency +/- anaemia
- Coeliac disease suspected or confirmed
- Unexplained abdominal pain and weight loss
- GORD/Dyspepsia
- Dysphagia/odynophagia
- Persistent vomiting and weight loss
- Screening/surveillance Barrett's oesophagus
- Screening/surveillance Gastric intestinal metaplasia

**Colonoscopy**

- Positive FOBT
- Screening/family history of CRC
- Surveillance, previous polyps
- Unexplained iron deficiency +/- anaemia
- Rectal bleeding
- Bloody diarrhoea with negative stool MC/S
- Change in bowel habit > 8 weeks
- Unexplained abdominal pain and weight loss
- After first episode of proven diverticulitis exclude cancer

Signature: \_\_\_\_\_

Referral valid for

- 3 MONTHS  12 MONTHS