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| **GENERAL PRACTITIONER REFERRAL (must complete this section)** |
| **PATIENT DETAILS** |
| **Family name:**  | **Given Names:**  |
| **Sex:**   | **Date of Birth:**   | **Age:**  |
| **Address:**   |
| **Phone (H):**   | **Phone (W):**   | **Phone (M):**   |
| **Email:**   |
| **Ethnicity / Aboriginal and Torres Strait Islander Status:** **Interpreter Required:**  o Yes o No (if yes, language spoken):  |
| **Medicare card no:**  IRN: Expiry: NOTE: If Medicare ineligible, fees will apply. Contact Triple I for details.  |
| **DVA Card Number:** Card Type: NOTE: If DVA Card Holder, refer to DVA unless Hospital Avoidance category of client.  |
| **Pension/Health Care Card No:**  | **Private Health Insurer:**   |
| **Marital Status:**  | **Occupation:**  |
| **Next of Kin Details:** **Name: Relationship to Carer:** **Contact Number:** **Address:**   |
| **REFERRING MEDICAL OFFICER’S DETAILS** |
| **Doctor's Name:**  | **Provider No:**  |
| **Phone:**  | **Fax:**  |
| **Address:**  |  |
| **Email:**  |  |

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| **Clinical Details** |
| **Relevant Medical History:** **Current Medications:**  |

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| **Referral for Positive FOBT Direct Access Colonoscopy (DAC)** |
| **SPECIALIST BEING REFERRED TO**:  |
|  |
| **Please circle/nominate a Specialist:** |
| **Liverpool Clinic:*** Dr Ken Koo (Coordinator)
 |  **Campbelltown Clinic:*** Dr Ian Turner (Coordinator)
 |  |
| \*If another specialist has a shorter wait time, the patient could be contacted and offered an earlier appointment. A new referral is not required. |
| **MEDICAL HISTORY:**   |
| Weight (kg):  | Height (m):  |
| Previous colonoscopy: Y / N | If YES - year of last colonoscopy: |
| **CURRENT SYMPTOMS:** |  |
| * Nil
* Iron deficiency anaemia
* Unexplained weight loss
* Rectal bleeding
 | * Unexplained abdominal pain
* Palpable or visible rectal/abdominal mass
* Other (specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |
| **Please tick ALL items:**   | YES | NO |
| Cardiac disease (e.g. IHD, heart failure, pacemaker, valve disease, coronary stent) |  |  |
| Chronic respiratory disease (e.g. COPD, poorly controlled asthma) |  |  |
| Chronic kidney disease EGFR < 60 ml/min/1.73m2 |  |  |
| Cirrhosis |  |  |
| Diabetes not on insulin |  |  |
| Diabetes on insulin |  |  |
| Obstructive sleep apnoea |  |  |
| Advanced malignancy |  |  |
| Impaired mobility affecting independence with bowel preparation (e.g. CVA, Parkinson’s) |  |  |
| Previous history of difficulties with anaesthesia |  |  |
| **Please tick ALL items:**   | YES | NO |
| On anticoagulant (warfarin, apixaban, dabigatran, rivaroxaban) |  |  |
| On antiplatelet other than aspirin (e.g. clopidogrel, prasugrel, ticagrelor, asasantin) |  |  |
| Is the patient anaemic or iron deficient? |  |  |
| Has the patient had a colonoscopy within the last 4 years? |  |  |
| Previous history of difficult colonoscopy (e.g. incomplete colonoscopy, complication) |  |  |
| Does patient require a specialist assessment for GI symptoms prior to colonoscopy? |  |  |
| Does the patient have capacity to understand instructions of the bowel preparation and advice of the risks and benefits of a colonoscopy? |  |  |
| Other issues - Please specify: |
| **For FOBT DAC Referrals please attach the following documents to this referral form*** **Patient Health Summary**
* **Positive FOBT result**
* **Recent blood tests – FBE, UEC, LFT, Iron studies**
* **Specialist Letters for relevant conditions**
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| **Date:**  | **Doctor’s signature:**  |