|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **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:** |