Sydney Gastroenterology

If you have any queries regarding this form, please call (02) 9707 3523

**FAX TO**
(02) 9709 5637

**EMAIL TO**
reception@sydneygi.com.au

# DIRECT ACCESS ENDOSCOPY REFERRAL FORM

## REFERRING DOCTOR INFORMATION

Referring Doctor _____ Provider Number _____

Address _____ Phone _____

Fax _____ CC (if requested) _____

**Requested procedure**

◯ Upper GI Endoscopy (Gastroscopy) ◯ Colonoscopy

Indications for Referral (please complete) _____

_____

Signature of referring doctor _____ Date ____ / ____ / ____

## PATIENT INFORMATION

Name _____ DOB ____ / ____ / ____

Address _____

Phone (H) _____ Phone (M) _____

Medicare Number _____ Reference Number _____

Private Health Fund _____ Member Number _____

## ANTI-COAG/ANTI-PLATELET THERAPY

| Type | Can it be stopped? | |
|---|---|---|
| ◯ None | ◯ Yes | ◯ No |
| ◯ Aspirin | ◯ Yes | ◯ No |
| ◯ Clopidogrel | ◯ Yes | ◯ No |
| ◯ Warfarin | ◯ Yes | ◯ No |
| ◯ Other | ◯ Yes | ◯ No |

## COMORBIDITIES

(must be completed)

◯ None

◯ Cardiac

◯ Respiratory

◯ Renal

◯ Diabetes ◯ Type 1 ◯ Type 2

◯ Vancomcin Resistant Enterococci/MRSA

◯ Blood Borne Virus (please specify) _____

## ALLERGIES

◯ No ◯ Yes Clinical Details/Adverse Reactions _____

## ADDITIONAL INFORMATION

_____

_____

_____

_____