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

SPECIALIST 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
- ◯ Endoscopic Ultrasound (EUS)
- ◯ Endoscopic retrograde cholangiopancreatography (ERCP)
- ◯ EMR / ESD
- ◯ Radiofrequency ablation (RFA)

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

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