



TheAlfred

GASTROINTESTINAL ENDOSCOPY SERVICE
ALFRED REQUEST FORM

U.R. [ ]
Surname [ ]
Given Names [ ]

[ ] Outpatient [ ] Inpatient Ward: [ ] Other Hospital [ ]

Patient's Name: [ ]
Date of Birth: [ ] / [ ] / [ ] Sex: M / F
Address: [ ]
Postcode: [ ]
Phone: (H) [ ] Phone: (W) [ ]
Phone: (Mobile) [ ]
Interpreter Required: Y / N Language: [ ]
Medicare: [ ]

Referring Doctor: [ ]
Address: [ ]
Postcode: [ ]
Phone: [ ] Fax: [ ]
CC (If Necessary): [ ]
Signature: [ ] Date: [ ]

[ ] GASTROSCOPY
Indication (Please provide details below)
[ ] Bleeding
[ ] Haematemesis/melaena (contact Gastro. Reg.)
[ ] Iron deficient anaemia (attach FBE/Fe studies)
[ ] Dysphagia
[ ] Loss of weight
[ ] Abnormal imaging (attach report)
[ ] Pain [ ] Dyspepsia
[ ] Reflux
[ ] Atypical chest pain
[ ] Nausea/vomiting/loss of appetite
[ ] Barrett's screening
[ ] Small bowel biopsy - coeliac screening
[ ] Varices: possible therapy
[ ] Other (details below)

[ ] COLONOSCOPY or
[ ] FLEXIBLE SIGMOIDOSCOPY
Indication (Please provide details below)
[ ] PR Bleeding [ ] Bright [ ] Dark/mixed
[ ] FOBT [ ] NBCSP
[ ] Iron Deficient Anaemia (attach FBE/Fe studies)
[ ] Altered bowel habit [ ] Diarrhoea [ ] Constipation
[ ] Known large polyp (attach report)
[ ] Abnormal imaging (attach report)
[ ] Surveillance [ ] Previous Ca [ ] Previous polyps
[ ] Family history Ca [ ] IBD (details below)
[ ] Loss of weight
[ ] Other (details below)

INPATIENT/COMPLEX/THERAPEUTIC REFERRALS: Discussed with [ ] Gastro. Reg. / [ ] Consultant [ ]
[ ] As Above [ ] ERCP [ ] Balloon Enteroscopy [ ] Antegrade [ ] Retrograde [ ] PEG

Details:

ANTI-COAG/ANTI PLATELET THERAPY:
[ ] NONE Can it be stopped?
[ ] 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
[ ] Vancomycin Resistant Enterococci:
[ ] Blood Borne Virus (please specify):

ALLERGIES:
[ ] NO [ ] YES

EXTRA INFO:

PLEASE FAX REQUEST SLIP TO 9076 0393. ANY ENQUIRIES PHONE 9076 0211

INCOMPLETE/INADEQUATE REFERRALS WILL BE RETURNED TO THE REFERRING DOCTOR.
PATIENTS WILL BE SENT A HEALTH QUESTIONNAIRE - ONLY WHEN COMPLETED AND
RETURNED CAN AN APPOINTMENT BE MADE.
PATIENTS MAY BE REFERRED TO ENDOSCOPY CLINIC FOR ASSESSMENT PRIOR TO PROCEDURE.

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