XY310640

Government of **Western Australia**
Department of **Health**

GASTROINTESTINAL PROCEDURE REQUEST FORM

ADMISSION DATE: _____

DIAGNOSIS: _____

Please use ID label or block print

SURNAME	UMRN	SEX
FORENAMES	BIRTHDATE	
PATIENT'S ADDRESS		

Patient Label

Name _____ Date of Birth _____ Gender _____

Medicare No _____ Ref No _____ Expiry _____

Address _____

Email _____

Telephone _____ Work _____ Mobile _____

Interpreter Required: ☐ Yes ☐ No Language _____

Patients referred to the Combined Endoscopy Service will be triaged for endoscopic procedures, depending on clinical requirements and best available booking times. Low-risk day procedures are being performed at Fremantle Hospital.

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☐ Gastroscopy ☐ Colonoscopy ☐ Gastroscopy & Colonoscopy
☐ Clinic Appointment only ☐ Clinic appointment and scope

Reason for Referral

Yes	**Comments**
☐ Abnormal Liver function / cirrhosis	
☐ Abdominal pain	
☐ Abnormal imaging	
☐ Change in bowel habit	
☐ Diarrhoea (chronic > 6/52)	
☐ Dyspepsia / reflux	
☐ Dysphagia	
☐ Family history of bowel cancer *(specify family member/s and aged diagnosed with bowel cancer)*	
☐ Fe def Anaemia for investigation	
☐ History of colorectal cancer or polyps	
☐ Follow-up eg varices, polyps, Barrett's	
☐ Persistent vomiting and nausea	
☐ Planned surgery or procedure specify	
☐ Positive celiac serology	
☐ Positive FOBT	
☐ PR Bleeding	
☐ Suspected IBD	
☐ Weight loss unexplained	

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Continued

Please use ID label or block print

SURNAME	UMRN	SEX
FORENAMES	BIRTHDATE	
PATIENT'S ADDRESS		

Patient Label

Relevant Medical History and Risk Factors For Procedure
(Please give details indicating severity, type)

Name _____ Date of Birth _____

Weight _____ Height _____ (Mandatory)

Interpreter Required: ☐ Yes ☐ No Language _____

Yes	**Indicate the following**
☐	Bleeding Disorders
☐	Diabetes
☐	Heart Disease ?stipulate if has stents & year
☐	Kidney Disease
☐	Liver Disease
☐	Lung or Airway Disease
☐	Obstructive Sleep Apnoea
☐	Well enough for bowel prep at home if required

Indicate Current Medications

Specify anticoagulants and or antiplatelets

☐ Allergies

Please Specify

☐ Iron Tablets

☐ NSAIDS

Clinical details (include previous findings and relevant information):
Eg. Previous GI surgery / history (Specify)

Procedure _____ Year _____

Findings _____

Please supply / attach a complete medication list

Referring Doctor _____

Practice Stamp

Telephone _____ Provider Number _____ Date _____

Please fax this referral to: FSH Endoscopy Service 08 6152 6804

FSH USE ONLY

DECISION	CATEGORY	SITE	REQUESTED PROCEDURALIST
☐ OPC	☐ Urgent	☐ FSH	_____
☐ Gastroscopy	☐ Cat 1 - <30 days	☐ Fremantle	_____
☐ Colonoscopy	☐ Cat 2 – 30-90 days		_____
☐ Reject	☐ Cat 3 – 90-360 days		_____