Western Health

Gastrointestinal Endoscopy Referral Form

Please fax referral to 8345 7378.

Incomplete referrals will be returned to the referring doctor.

For any booking enquiries phone 8345 6015.
For clinical queries please contact the Gastroenterology Endoscopy Registrar via switchboard on 8345 6666.

Patient details

Name: _____
Date of Birth: _____
Gender: _____
Address: _____
Suburb: _____
Postcode: _____
Preferred phone number: _____
Additional phone numbers: _____
Medicare Number: _____
Private health fund details (if applicable):
_____

WHAD179a

- **Pages 1-2 of this booklet must be completed by ALL referring doctors.**
- **In addition, the top half of page 3 (Western Health referring clinician section) and page 4 (consent form) must be completed by referring doctors from Gastroenterology and WH Surgical Units performing the endoscopic procedure(s) requested.**
- **Incomplete forms will be returned to the requesting clinician.**

Referring doctor/practitioner details

Name:
Practice name:
Referring doctor provider number:
Practice Address:

Suburb:
Postcode:
Phone:
Fax:

Date: _____

☐ GP
☐ Specialist Private Rooms
☐ Emergency Department WH
☐ Specialist Clinic Western Health
Clinic Name: _____
☐ Other Department Western Health: _____
☐ Inpatient unit Western Health: _____
☐ Other hospital: _____

Interpreter required ☐ Yes Language (specify): _____

Diagnostic Lower GI Endoscopy Request

☐ **Colonoscopy** ☐ **Flexible Sigmoidoscopy**

Indication A: Symptoms and Investigations

☐ Positive iFOBT *(Attach FOBT results)*
  ☐ **NBCSP**
  ☐ Not NBCSP
☐ Anaemia: *(provide results below or attach results)*
☐ Rectal bleeding - months duration: _____
☐ Age ≥ 60 years
☐ Change in bowel habit
  ☐ Constipation - months duration: _____
  ☐ Diarrhoea - months duration: _____
  ☐ Constipation & diarrhoea - months duration: _____
☐ Abdominal pain - months duration: _____
☐ Possible IBD (Inflammatory Bowel Disease)
☐ Unintentional weight loss (≥10% of body weight)
☐ Primary cancer of unknown origin
☐ Abnormal imaging suggestive of colorectal cancer
☐ Palpable mass (or on sigmoidoscopy)
  ☐ Abdominal ☐ Rectal
☐ Hb _____ ☐ MCV _____ ☐ Ferritin _____
☐ Calprotectin _____ ☐ CRP _____
Clinical Notes: _____

Indication B: Colonoscopy for surveillance or screening

Please refer to NHMRC surveillance guidelines
Date of last colonoscopy _____
Must attach last colonoscopy report and histology report
☐ Adenoma surveillance risk category: ☐ A ☐ B ☐ C ☐ D
☐ IBD Surveillance group: ☐ 1 ☐ 2 ☐ 3
  IBD type: ☐ Ulcerative colitis ☐ Crohn's
  Date of IBD Diagnosis: _____
  Primary sclerosing cholangitis date of diagnosis: _____
☐ Family history screening risk category: ☐ 1 ☐ 2 ☐ 3
  Familial Hereditary Syndrome: _____
☐ Colorectal Cancer surveillance
  Date of colorectal cancer diagnosis: _____
☐ Other: _____

Indication C: Therapeutic Colonoscopy

☐ Haemorrhoid banding
☐ EMR / polypectomy for colorectal polyp ≥ 2 cm
☐ EMR / polypectomy for colorectal polyp < 2 cm
☐ Colon stenting
☐ APC
☐ Dilatation
☐ APC for radiation proctitis
☐ Other: _____

Clinical Notes: _____

Diagnostic Upper GI Endoscopy Request

☐ **Gastroscopy**

Indication A: Symptoms and investigations:

(tick all that apply and provide copy of relevant results)

Bleeding:
☐ Haematemesis ☐ Melaena
☐ Iron deficiency anaemia *(attach Hb and Ferritin level)*
☐ Abnormal blood test *(please circle)*:
low Hb, low ferritin, microcytosis, hypochromasia, raised platelets

Suspected malignancy:
☐ Age ≥ 55 years ☐ Dysphagia
☐ Suspected upper GI malignancy on imaging *(attach report)*
☐ Nausea / vomiting, persistent (≥ 6 weeks)
☐ Loss of appetite ☐ Early satiety
☐ Unexplained weight loss (≥10% of body weight)
☐ Known: Barrett's oesophagus / gastric intestinal metaplasia / gastric dysplasia / atrophic gastritis / *(circle all that apply)*
☐ Family history of upper GI cancer in 1st degree relative

Other symptoms:
☐ GORD ☐ Not responsive to PPI ☐ Recent onset
☐ Dyspepsia ☐ Not responsive to PPI and/or *H. pylori* treatment *(please circle)*
☐ Upper abdominal pain
☐ Suspected coeliac disease *(with positive serology – attach results)*
☐ Other: _____

Indication B: Gastroscopy for surveillance:

Date of last gastroscopy _____
Must attach last gastroscopy report and histology report
☐ Barrett's oesophagus ☐ Gastric ulcer
☐ Varices ☐ oesophageal ☐ gastric
☐ Oesophagitis ☐ Severe erosive (LA Grade C-D) ☐ Eosinophilic
☐ Gastric dysplasia ☐ Gastric intestinal metaplasia
☐ Previous upper GI cancer (Date of diagnosis _____)
☐ Previous therapeutic procedure (EMR, RFA, upper GI surgery) (Date of procedure _____)
☐ Syndrome: ☐ APC ☐ Lynch
☐ Other: _____

Indication C: Therapeutic Gastroscopy

☐ Barrett's with dysplasia ☐ Varices (oesophageal)
☐ Varices (gastric) ☐ Dilatation ☐ Gastric polyp(s)
☐ Duodenal polyp(s) ☐ Upper GI stenting ☐ PEG insertion
☐ Other: _____
Clinical Notes: _____

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Gastrointestinal Endoscopy Referral Form continued

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Patient details

UR number:

Surname:

First name:

Date of birth:

Indication D: Inadequate bowel preparation at recent colonoscopy

☐ Repeat colonoscopy due to inadequate bowel preparation.
See original endoscopy referral form for clinical details.

Indication D: Pre-Operative Assessment Gastroscopy

☐ Known upper GI cancer
☐ Anti-reflux surgery
☐ Other: _____
☐ Bariatric surgery
☐ Hiatus Hernia

ERCP Request: *Attach relevant imaging report and blood tests*

☐ Bile duct stone
☐ Bile duct stricture
☐ Tumour/mass lesion causing jaundice
☐ Biliary stent: ☐ change ☐ removal
☐ Other: _____

Clinical Notes: _____

EUS Request: *Attach relevant imaging report and blood tests*

☐ Bile duct abnormality
☐ Pancreatic duct abnormality
☐ Pancreatic cyst
☐ Pancreatic mass lesion
☐ Ampullary lesion
☐ Assessment of subepithelial lesion
☐ Other lesion for FNA
☐ Pseudocyst drainage
☐ Other: _____

Clinical Notes: _____

Additional clinical information required:

Please include details about risk factors:

☐ None

☐ Family history of gastro-intestinal malignancy
Details: _____

☐ Current smoker
☐ Recreational drug use
☐ Alcohol excess
☐ Obesity

Additional relevant medical details:

☐ Diabetes: ☐ Type I ☐ Type II ☐ Insulin requiring
☐ No allergies to medication
☐ Allergies: _____
☐ Previous malignancy: _____
☐ Current malignancy: _____

Other relevant information

_____

_____

_____

_____

Anaesthetic Risk:

Please indicate if patient suffers from any of the following:

☐ BMI >40
☐ Symptomatic ischaemic heart disease
☐ Valvular heart disease or congestive heart failure
☐ Severe obstructive sleep apnoea
☐ Respiratory disease requiring oxygen therapy or limiting patient's day to day activities (NYHA class 3)
☐ Chronic kidney disease requiring dialysis or pre-dialysis
☐ Patients with neuromuscular disorders (e.g. myasthenia gravis, muscular dystrophy, cerebral palsy)
☐ Known bleeding disorder
☐ Known prior severe reaction to anaesthesia e.g. malignant hyperthermia, suxamethonium apnoea, severe post-operative nausea or vomiting or known difficult airway

Note: If yes to any of these indicators, patient is not suitable for Sunbury Day Hospital

Anti-Coagulation / Anti-Platelet Therapy*

☐ None

	Can it be stopped?				Can it be stopped?		
☐ Aspirin*	☐ Yes	☐ No	☐ Unsure	☐ Rivaroxaban	☐ Yes	☐ No	☐ Unsure
☐ Clopidogrel	☐ Yes	☐ No	☐ Unsure	☐ Dabigatran	☐ Yes	☐ No	☐ Unsure
☐ Ticagrelor	☐ Yes	☐ No	☐ Unsure	☐ Apixaban	☐ Yes	☐ No	☐ Unsure
☐ Prasugrel	☐ Yes	☐ No	☐ Unsure	☐ Low Molecular Weight Heparin	☐ Yes	☐ No	☐ Unsure
☐ Warfarin	☐ Yes	☐ No	☐ Unsure	☐ Other	☐ Yes	☐ No	☐ Unsure

Comments: _____

* *Note that aspirin can nearly always be continued*

Risk factors for poor bowel preparation for colonoscopy:

Please indicate if patient suffers from any of the following:

☐ Constipation
☐ Obesity
☐ Diabetes
☐ Stroke
☐ Chronic opioid use
☐ Parkinson's Disease
☐ Tricyclic antidepressant use

Western Health

Gastrointestinal Endoscopy Referral Form continued

Patient details

UR number: _____

Surname: _____

First name: _____

Date of birth: _____

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Western Health Gastroenterology or Surgical Unit referring clinician to complete:

Requesting Unit: _____

Admit under Doctor/Practitioner: _____

Nominated Consultant Only ☐

Any proceduralist ☐

Provisional Diagnosis:

BMI *(required)*

- ☐ BMI < 18.5
- ☐ BMI 18.5-40
- ☐ BMI 40-45
- ☐ BMI 45-50
- ☐ BMI > 50

Procedure:

Specific endoscopy equipment required:

_____

_____

Admission details

- ☐ Public
- ☐ Workcover
- ☐ Private
- ☐ TAC
- ☐ Overseas Visitor
- ☐ Veteran Affairs - DVA

Admission Type

- ☐ Day case
- ☐ Admit day prior (give clinical indication) _____
- ☐ Admit after procedure
- ☐ Multi day (____ days expected)

- ☐ Standard bowel prep
- ☐ Enhanced bowel prep
- ☐ Clinic review for individualised prep education

Time required for procedure: _____ minutes

Suggested triage category

☐ cat 1 ☐ cat 2 ☐ cat 3 ☐ cat 3 surveillance (due: _____ month/year)

Signature of Medical Officer/Practitioner: _____ Date: _____

Name of Medical Officer/Practitioner: _____ Contact number: _____

Endoscopy booking office only – endoscopy triage officer to complete:

☐ **Insufficient information to triage: Additional information required. Return to referring doctor.**

☐ **Sufficient information provided, but not suitable to proceed directly to endoscopy procedure. Redirect to appropriate clinic:**

- ☐ Gastroenterology Clinic
- ☐ Endoscopy Interventional Clinic
- ☐ Endoscopy Standard Clinic
- ☐ IBD Clinic
- ☐ Colorectal Surgical Clinic
- ☐ Upper GI Surgical Clinic
- ☐ Liver Clinic
- ☐ Other WH clinic: _____

☐ **Sufficient information to proceed directly to endoscopy procedure:**

- ☐ Gastroscopy
- ☐ Colonoscopy
- ☐ Flexible Sigmoidoscopy
- ☐ Rectal Bleeding Clinic
- ☐ ERCP
- ☐ EUS
- ☐ Other: _____

Notes: _____

Triage category:

Colonoscopy or Flexible Sigmoidoscopy:

- ☐ Category 1 (30 days)
- ☐ Category 2 (60 days)
- ☐ Category 3 (180 days)
- ☐ Category 3 Surveillance (due: _____ month/year)

Gastroscopy, ERCP, EUS, other:

- ☐ Category 1 (30 days)
- ☐ Category 2 (60 days)
- ☐ Category 3 (180 days)
- ☐ Category 3 Surveillance (due: _____ month/year)

Suitable Western Health campus:

- ☐ Footscray Hospital
- ☐ Sunshine Hospital
- ☐ Sunbury Day Hospital

Recommended bowel prep for colonoscopy:

- ☐ Standard bowel prep
- ☐ Enhanced bowel prep
- ☐ Clinic review for individualised prep education

Additional details:

- ☐ Suitable for Nurse Practitioner Endoscopist
- ☐ NBCSP confirmed
- ☐ PAC Medical Review
- ☐ Anticoagulation management
- ☐ Diabetic Management
- ☐ BMI over 50 – book on high BMI list

Name of triaging officer: _____

Signature: _____ Date: _____

Western Health

Consent Form for Endoscopic Procedure

Patient details

UR number: _____

Surname: _____

First name: _____

Date of birth: _____

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Western Health Waiting List Referral and Consent for Procedure(s)

I, _____ understand that I will be referred for placement on the hospital's wait list and
given name surname

give my consent for the following _____
specify operations(s) / procedure(s)

being performed on _____
myself or name and relationship to patient if competed by person other than patient

I have been advised and understand that:

a. I will receive written confirmation of waiting list placement from the hospital. I also understand I may receive my surgery at another Western Health campus by a different surgeon than the surgeon referring me to the waiting list.
b. I understand that at times representatives of medical device and prosthetic suppliers may be present during my procedure.
c. If I have further questions about my condition and/or the above procedure(s), I will have the opportunity to discuss them with doctors at the hospital.
d. If I am concerned about any changes in my condition or health, that occurs whilst I am on the waiting list I should contact my General Practitioner for advice.
e. If I have any further questions regarding placement on the waiting list, I should contact the Booking Office at the relevant hospital.
f. I also consent to such further operative procedures as may be found necessary to be performed during the course of the operation(s)/procedure(s) stated above. In conjuction with the above stated operation(s), I consent to the administration of such anaesthetics as may be considered by the anaesthetist to be necessary or advisable.
g. I understand that during the procedure photographs of the procedure or of operative findings may be obtained. I understand that such photos will be regarded as part of my medical record and used ethically for teaching and clinical meetings where appropriate.
h. If I have elected to be a public patient I understand that a registrar may perform the procedure or give the anaesthetic under the supervision of the consultant specialist.
i. I understand the proposed procedure and that in the case of significant delay in time from addition to the wait list and surgery, consent may need to be reobtained or confirmed.

Risks and complications discussed include: _____

_____

_____

Other options for treatment have been discussed with me: ☐ No ☐ Yes

I have been given the consent information sheet for the surgery/procedure above: ☐ No ☐ Yes

Signed: _____ Self or relationship to patient: _____ Date: ____ /____ /_____

Reason if consent given by person other than patient: _____

_____

_____

Name of Interpreter: _____

Reason for person other than qualified interpreter: _____

Confirmation by Medical Officer/Practitioner

I, _____ have explained to the *patient/person responsible for the patient, the nature of the above operation(s)/procedure(s). In my opinion, **he/she understood the explanation. **strike out not applicable

Signature of Medical Officer/Practitioner: _____ Date: ____ /____ /_____