

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): _____

Please complete this form in full. Incomplete forms will be returned to the requesting clinician.

Referring doctor/practitioner details

Name: _____ Suburb: _____ GP
Practice name: _____ Postcode: _____ Specialist Private Rooms
Referring doctor provider number: _____ Phone: _____ Emergency Department WH
Practice Address: _____ Fax: _____ Specialist Clinic Western Health
Date: _____ 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 Colon stenting
 EMR / polypectomy for colorectal polyp ≥ 2 cm APC
 EMR / polypectomy for colorectal polyp < 2 cm 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:

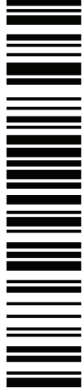
Date of last gastroscopy _____
Must attach last gastroscopy report and histology report
 Barrett's oesophagus Gastric ulcer
 Varices oesophageal gastric
 Oesophagitis Severe erosive (LA Grade C-D) Eosinophilic
 Gastric dysplasia Gastric intestinal metaplasia
 Previous upper GI cancer (Date of diagnosis _____)
 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: _____

Gastrointestinal Endoscopy Referral Form continued

WHCOR179b



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 Bariatric surgery

Anti-reflux surgery Hiatus Hernia

Other: _____

ERCP Request: Attach relevant imaging report and blood tests

Bile duct stone Biliary stent: _____

Bile duct stricture change removal

Tumour/mass lesion causing jaundice Other: _____

Clinical Notes: _____

EUS Request: Attach relevant imaging report and blood tests

Bile duct abnormality Assessment of subepithelial lesion

Pancreatic duct abnormality Other lesion for FNA

Pancreatic cyst Pseudocyst drainage

Pancreatic mass lesion Other: _____

Ampullary lesion

Clinical Notes: _____

Additional clinical information required:

Please include details about risk factors:

None

Family history of gastro-intestinal malignancy
Details: _____

Current smoker Alcohol excess

Recreational drug use 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

<input type="checkbox"/> Aspirin*	Can it be stopped?	<input type="checkbox"/> Rivaroxaban	Can it be stopped?
<input type="checkbox"/> Clopidogrel	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	<input type="checkbox"/> Dabigatran	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
<input type="checkbox"/> Ticagrelor	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	<input type="checkbox"/> Apixaban	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
<input type="checkbox"/> Prasugrel	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	<input type="checkbox"/> Low Molecular Weight Heparin	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
<input type="checkbox"/> Warfarin	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	<input type="checkbox"/> Other	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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 Stroke Tricyclic antidepressant use

Obesity Chronic opioid use

Diabetes Parkinson's Disease