

South Metropolitan Health Service

Please use ID Label or block print

Gastroenterology Procedure Request Form

Surname: _____ UMRN: _____

Given Name: _____ DOB: ___/___/___

ADDRESS: _____

Gender: _____ Marital Status: _____

FURTHER DETAILS:

Phone (H) _____ (W) _____ Mobile: _____

Previous other surnames (eg. Maiden): _____

For Ambulatory Surgery referrals please mark two or more preferred specialists

Pearce Lawrance Chong Rofe Ayonrinde Galhenage Cullingford
Ahmad Fletcher

URGENCY: Urgent: (< 30 days) Semi-urgent: (30-90 days) Routine:

PROCEDURE REQUESTED: Gastroscopy ERCP Colonoscopy
Other (please state:) _____

NATIONAL BOWEL CANCER SCREENING PROGRAM Yes No

INDICATIONS: _____

FAMILY HISTORY (For each family member affected by colonic cancer please state their relationship to the patient and age at diagnosis) -

PAST MEDICAL HISTORY (Specify):

SPECIFY:

_____ Heart Disease: _____

_____ Lung Disease: _____

_____ Bleeding Disease: _____

_____ Diabetes: _____

MEDICATIONS (Specify):

OTHER MEDICATIONS (List):

Anticoagulants: _____
Aspirin/ NSAID's: _____
Iron Tablets: _____

ALLERGIES (List): _____

Interpreter Required: YES NO Language: _____

REFERRING DOCTOR:

Name: _____ REFERRAL DATE ___/___/___

Address: _____

Phone: _____ Fax: _____

Phone No. (W) _____ (F) _____

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