

Speciality Referred to: **Gastrointestinal Endoscopy to Test Referral**

ATTN: Dr Alan Atherstone, Surgical Outpatient Department,
Rockhampton Hospital, QLD 4700.

Please print **Adult Integrated Pre-Procedure Screening Tool** for the patient to fill in and bring to their appointment or fax it with this referral to 49206301. www.health.qld.gov.au/cq/gp/

See **Endoscopy Referral Requirements** for more information at www.health.qld.gov.au/cq/gp/

<TodaysDate>

<Practice>

Dr: <DrFirstName> <DrSurname>

<UsrAddress>

<DrQualifications>

<DrProviderNo>

Ph: <UsrPhone> Fax: <UsrFax>

Name: <PtFormalName>

Medicare card: <PtMCNo> <PtMCExpiry>

D.O.B.: <PtDoB>

Concession card: <PtPensionNo>

Address: <PtAddress>

DVA card: <PtDVANo>

Referral validity period: <Referral validity
period>

Phone: <PtPhoneH>

If interpreter required indicate language

Mobile: <PtPhoneMob>

here: <If interpreter required indicate
language here:>

Requested Procedure: <Requested Procedure>

For GASTROSCOPY see below: <For GASTROSCOPY (fill in below)>

Indication <Indication>

Bleeding <Bleeding>

Abnormal Imaging <Abnormal Image>

Barrett's Screening <Barretts Screening>

Date of last endoscopy <Date of last endoscopy:>

Small bowel biopsy - coeliac screening include antibody result <Small bowel biopsy -
Coeliac screening inc. antibody result>

Dysphagia <Dysphagia>

Nausea/Vomiting/Loss of Appetite <Nausea and Vomiting/Loss of appetite>

Weight Loss <Weight Loss>

Pain <Pain>

Other relevant information: <Other relevant information>

For COLONOSCOPY/FLEXIBLE SIGMOIDOSCOPY/NBCSP see below: <COLONOSCOPY / FLEXIBLE SIGMOIDOSCOPY / NBCSP (fill in below)>

Indication <Indication:>

PR Bleeding <PR Bleeding>

Altered Bowel Habit <Altered Bowel Habit>

Constipation <Constipation>

Diarrhoea <Diarrhoea>

Area of Pain <Area of pain>

Surveillance <Surveillance (refer to www.health.qld.gov.au/cq/gp/)>

Please provide more information if the above is yes: <If yes to the above please provide more information>

Date of last endoscopy: <Date of last endoscopy>

Other relevant information <Other relevant information>

Investigations: All investigations should be < 3months old. *Iron studies, Urea and Electrolytes. ECG for males >45 yrs and females >50 yrs unless they have a risk factor: hypertension, smoking, diabetes, gout, family hx or known ischaemic heart disease/angina or cardioactive drugs (e.g. digoxin, amiodarone)*

<Ix>

For ALL PROCEDURES fill in the following: <For ALL PROCEDURES fill in the following:>

Haemoglobin level <Hb Level>

Observations: <Observations>

Anti-coagulation/Anti-platelet therapy <Type of Anticoagulant/Antiplatelet therapy>

<Other anticoagulant therapy>

Can it be stopped? <Can anticoagulant be stopped?>

Comorbidities: <Comorbidities please select>

Specify more information if the above is yes: <If yes to the above please specify more

information>

Reactions:

<Reactions>

Current Medications:

<CurrentRx>

Past Medical History (active):

<PMHActive>

Any Anaesthetic problems? <Any Anaesthetic problems?>

Procedure explained to the Patient: <Procedure explained to the Patient>

Signature:

Dr: <DrFirstName> <DrSurname>