GP Colonoscopy Referral Form

Dr Robert Gandy
UPPER GASTROINTESTINAL SURGEON

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PATIENT DETAILS				**PRACTICE DETAILS**	
Medicare No.				Name of GP	
Title		Surname		Name of Practice	
First Names				Address	
Date of Birth					
Address				Post Code	
				Telephone No.	
Post Code				Provider Number	
Best Contact No.				GP Referral Date	
Insurance fund	Policy no.			**GP Signature**	
Dates Patient Unavailable	1)	2)			

Please tick appropriate box

TEST REQUIRED	**COLONOSCOPY**	**ROUTINE**		**URGENT**	

CLINICAL DETAILS - Reasons for Referral for colonoscopy:

History of presenting symptoms

> 55 years, change in bowel habit or +ve FOBT	NO		YES		
Family history or national screening programme	NO		YES		If yes, refer for urgent endoscopy or cancer 2WW
Minor rectal bleed or malena (No active bleeding)	NO		YES		If yes, refer for urgent endoscopy or cancer 2WW
Unexplained weight loss	NO		YES		If yes, refer for urgent endoscopy or cancer 2WW
Iron deficiency anaemia (Likely lower GI)	NO		YES		If yes, refer for urgent endoscopy or cancer 2WW

Has the patient had a previous colonoscopy or require surveillance colonoscopy? YES ☐ NO ☐

If yes, please provide details

Anticipated diagnosis? Normal colonoscopy ☐ Inflammatory bowel ☐ Diverticulitis ☐ Polyp or mass lesion ☐

(please indicate with a tick)

Diabetes YES ☐ NO ☐ **IHD** YES ☐ NO ☐ **Hypertension** YES ☐ NO ☐

Past Medical History

Further Information

Previous Endoscopy YES ☐ NO ☐

Year _____ Diagnosis _____

Drug Medication (please complete or enclose computer print out)

Clopidogrel YES ☐ NO ☐ **On Warfarin or other anticoagulant** YES ☐ NO ☐ **Aspirin** YES ☐ NO ☐

Allergies YES ☐ NO ☐ If yes, please give details

Smoker YES ☐ NO ☐ If yes, please give details Cigarette per day ☐

Alcohol YES ☐ NO ☐ If yes, please give details No. of units per week ☐

Dr Gandy or a member of his team will contact patient via telephone to arrange procedure.