GP Gastroscopy 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 (delete)	Medicare /Private insurance / other				
Dates Patient Unavailable	1)	2)			

Please tick appropriate box

TEST REQUIRED	**GASTROSCOPY**	**ROUTINE**		**URGENT**	

CLINICAL DETAILS - Reasons for Referral for endoscopy:

History of presenting symptoms

< 55 years, symptoms resistant to treatment >3/12	NO		YES		
New onset dyspepsia > 55 years	NO		YES		If yes, refer for urgent endoscopy or cancer 2WW
Minor GI bleed (No evidence active bleeding)	NO		YES		If yes, refer for urgent endoscopy or cancer 2WW
Dysphagia	NO		YES		If yes, refer for urgent endoscopy or cancer 2WW
Iron deficiency anaemia (Likely upper GI)	NO		YES		If yes, refer for urgent endoscopy or cancer 2WW

Has the patient had a therapeutic course of PPI or other dyspeptic treatment? YES ☐ NO ☐

If yes, please provide details _____

Anticipated diagnosis? Normal Endoscopy ☐ Duodenal Ulcer ☐ Gastric Ulcer ☐ Hiatus Hernia ☐

(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** YES ☐ NO ☐ **On NSAID's** 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 the procedure.