EASTERN SUBURBS
SURGICAL SPECIALISTS

Dr Robert Gandy
(MB ChB, MS, MRCS, FRACS)
Upper GI, Bariatric, HPB and
General Surgeon

Referral form

Patient details

Name _____ DOB _____

Address _____

Phone _____

Staff to contact patient Yes or no

Referrer details

Doctor _____ Provider _____

Clinic _____

Phone _____ Fax _____

❑ Duration of referral 3 months or 12 months

Reason for consultation

❑Gallbladder
❑Hernia
❑Liver
❑Pancreas
❑Reflux
❑Biliary
❑Gastric
❑Other _____

❑Obesity /metabolic
❑Endoscopy
❑Colonoscopy
❑Follow up
❑Abdominal pain
❑Skin lesions
❑Second opinion

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