ST VINCENT'S HOSPITAL SYDNEY

Positive Faecal Occult Blood Test (FOBT) Colonoscopy Referral

MRN			SURNAME
GIVEN NAME(S)			
DOB	SEX	AMO	WARD/CLINIC

(Please enter information or affix Patient Information Label)

Patient details	Referring Doctor details
Name:	Name:
Date of Birth:	Date of Referral:
☐ Aborginal ☐ Torres Strait Islander	Provider No:
Address:	Address:
Suburb: Postcode:	Suburb: Postcode:
Email:	Phone:
Phone:	Fax:
Medicare No:	Email:
Gender: ☐ M ☐ F ☐ Other:	GP Signature:
Weight (kg):	**Referral valid for: ☐ 12 months ☐ Indefinite**
SVH MRN (if known):	Interpreter needed: ☐ Yes ☐ No Language:

One Colonoscopist (Gastroenterologist or Surgeon*) must be selected

☐ Dr D Williams	☐ Dr N De Luca	☐ Dr R Feller
☐ Dr S Ghaly	☐ Dr M Danta	☐ Dr A Stoita
☐ Dr A Kim	☐ Dr A Meagher*	☐ Dr R Gett*
☐ Dr G Owen*	**Are you happy for the patient to see the next available Endoscopist:** ☐ Yes ☐ No	

Reason(s) for Referral	Medical History
☐ FOBT + Date of test: ..... / ..... /	☐ **Heart disease:** ☐ Coronary artery stents ☐ Heart failure ☐ Pacemaker / defibrillator ☐ Angina ☐ Prosthetic valve ☐ Atrial Fibrillation
☐ NBCSP ☐ Yes ID No.: ..... (attach results)	
☐ Date of last Colonoscopy: ..... / ..... /	
☐ Allergies	☐ **Diabetes** ☐ Type I ☐ Type II
☐ Smoker: ..... pack years	☐ **Lung disease**
☐ ETOH	☐ **Liver disease**
	☐ **CVA / TIA**
☐ Attach blood test results	☐ **Malignancy**
	☐ **Kidney disease** ☐ GFR ..... ☐ Creat .....
☐ **Able to give informed consent**	☐ **Mental Health:**

Medications

☐ Insulin	☐ Warfarin	☐ Clopidogrel (Plavix)
☐ Xarelto	☐ Eliquis	☐ Pradaxa
☐ Steroids	☐ Immunosuppression	☐ SGLT2 inhibitors
☐ Other:		

Comments

Please fax referral to (02) 8382 3983. Incomplete referrals will be returned before any action.
Email: SVHS.Gastro@svha.org.au Phone: 8382 2061

POSITIVE FOBT COLONOSCOPY REFERRAL

BINDING MARGIN - NO WRITING
St Vincent's Hospital Sydney Limited
ABN 77 054 038 872

Updated Dec 2019

G:SVH:FORMS:2018