ST VINCENT'S HOSPITAL
SYDNEY

Email: SVHS.Gastro@svha.org.au
Fax: 8382 3983
Phone: 8382 2061

Gastroenterology Outpatient Clinic Referral

Complete Referring Doctor Details or Overlay with Stamp / Sticker

Referring Doctor: _____ Date of Referral: _____
Provider No.: _____
Practice Name: _____
Street: _____ Suburb: _____ Postcode: _____
Phone: _____ Fax: _____ Email: _____

Please Tick Box

Clinic Doctors: ☐ Dr David Williams ☐ Dr Alina Stoita

Patients referred to this service may be seen by an alternative (locum) physician

Patient Details

Surname		Given Name	
Date of Birth		Gender	☐ M ☐ F ☐ Other
Street		Weight (kg)	
Suburb		Email	
Postcode		Mobile / Phone	
Medicare No.		SVH MRN (if known)	

Referral

Reason for Referral	☐ FOBT ☐ Iron deficiency anaemia ☐ Dysphagia ☐ PR bleeding ☐ Sustained change bowel habit ☐ GORD ☐ Diagnosis coeliac disease ☐ Other .... ☐ Surveillance Colonoscopy: ☐ Family history CRC ☐ Personal history CRC/polyps ☐ Surveillance Barrett's ☐ Screening Colonoscopy: ☐ Family history CRC	
Relevant Test & Endoscopy Results (attach if possible)		Date of last: Endoscopy ..... Colonoscopy .....
Medical History	☐ Heart disease ☐ Lung disease ☐ Liver disease ☐ Malignancy ☐ Coronary artery stents ☐ Pacemaker/defibrillator ☐ Diabetes: ☐ Type 1 ☐ Type 2 ☐ Other:	
Medications	☐ Insulin ☐ Warfarin ☐ Clopidogrel (plavix) ☐ Xarelto ☐ Eliquis ☐ Pradaxa ☐ Steroids ☐ Immunosuppression ☐ Other	
Comments		
Interpreter Needed	☐ Yes ☐ No If Yes, preferred language:	

HOSPITAL USE ONLY

Priority:	☐ Urgent (30 days) ☐ Semi-urgent (90 days) ☐ Routine (365 days)	Clinic	Gastroenterology
Appointment Date:		Appointment Time:	
Interpreter Booked:	☐ Yes ☐ No		

GASTROENTEROLOGY OUTPATIENT CLINIC REFERRAL

August 2018
SV018*****
G:SVH:FORMS:2018