



Colonoscopy Referral Form

Referral

Referral:	<input type="checkbox"/> Public	<input type="checkbox"/> Private
Also Gastroscopy?	<input type="checkbox"/> No	<input type="checkbox"/> Yes

Please attach indication for gastroscopy:

Rx, H.Pylori, previous Ix, Ba study

Bundaberg: <input type="checkbox"/> Dr Grace Lim <input type="checkbox"/> Dr Kevin Hung <input type="checkbox"/> Dr Bee Kiat Ang <input type="checkbox"/> Dr Rasika Kotakadeniya	Hervey Bay / Maryborough: <input type="checkbox"/> Dr Ahmad Hooshyari (Gastrosopies only) <input type="checkbox"/> Dr Polbert Diaz <input type="checkbox"/> Dr Sasikaran Nalliah <input type="checkbox"/> Dr Sivananthan Suntharalingam <input type="checkbox"/> Dr Ephram Lye <input type="checkbox"/> Dr Gabriela Strey
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Referring Practitioner Information

Surname:	Given Name:
Address:	
Phone:	Date:
Signature:	

Patient details

Surname:	Given Name:
DOB:	Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male
Address:	Postcode:
Home Phone:	Mobile:
Pt Height:	Pt Weight:
	BMI:

Presenting Problems

Colorectal symptoms <input type="checkbox"/> No <input type="checkbox"/> Yes	Recent symptoms (6 – 12 months) <input type="checkbox"/> No <input type="checkbox"/> Yes	Rectal bleeding <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Mixed with stool <input type="checkbox"/> Frank
Loss of weight <input type="checkbox"/> No <input type="checkbox"/> Yes Amount & timeframe:	Diarrhoea <input type="checkbox"/> No <input type="checkbox"/> Yes Duration:	Abdominal pain <input type="checkbox"/> No <input type="checkbox"/> Yes Describe:
Constipation <input type="checkbox"/> No <input type="checkbox"/> Yes Duration:	Other symptoms: <input type="checkbox"/> No <input type="checkbox"/> Yes Describe:	



<p>Fe+ deficiency anaemia</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p style="color: red;">Please attach iron studies</p>	<p>Faecal occult blood</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p style="color: red;">Please attach results</p>	<p>NBCSP</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p style="color: red;">Require NBCSP results for reporting</p>
<p>Findings on digital examination</p> <p><input type="checkbox"/> Rectal mass <input type="checkbox"/> Haemorrhoids <input type="checkbox"/> Fissure <input type="checkbox"/> NAD</p>	<p>Previous barium enema</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p style="color: red;">Please attach report</p>	<p>Previous colonoscopy</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Date: ____ / ____ / ____</p> <p style="color: red;">Please attach report</p>
<p>Previous colorectal cancer</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p style="color: red;">Please attach D/C summary/report</p>	<p>Previous polyps</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p style="color: red;">Please attach report</p>	

Family History

Family history of colorectal cancer:	<input type="checkbox"/> No	<input type="checkbox"/> Yes
No of 1 st degree relatives with colorectal cancer:		
Age of 1 st degree relatives with colorectal cancer:		
No of 2 nd degree relatives with colorectal cancer:		
Age of 2 nd degree relatives with colorectal cancer:		
Family history of polyps:	<input type="checkbox"/> No	<input type="checkbox"/> Yes

Anticoagulant / anti-platelet therapy:	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Describe:	<p>.....</p> <p>.....</p>	
Significant cardiovascular / respiratory disease:	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Describe:	<p>.....</p> <p>.....</p> <p>.....</p>	

Please complete all fields and submit with results/reports and full patient Health Summary