



The Alfred

GASTROINTESTINAL ENDOSCOPY SERVICE
ALFRED REQUEST FORM

Surname

Given Names

Outpatient Inpatient Ward: Other Hospital

Patient's Name:
Date of Birth: Sex: M / F
Address:
Postcode:
Phone: (H) Phone: (W)
Phone: (Mobile)
Interpreter Required: Y / N Language:
Medicare:

Referring Doctor:
Address:
Postcode:
Phone: Fax:
CC (If Necessary):
Signature: Date:

- GASTROSCOPY
Indication (Please provide details below)
Bleeding
Haematemesis/malaena (contact Gastro. Reg.)
Iron deficient anaemia (attach FBE/Fe studies)
Dysphagia
Loss of weight
Abnormal imaging (attach report)
Pain
Dyspepsia
Reflux
Atypical chest pain
Nausea/vomiting/loss of appetite
Barrett's screening
Small bowel biopsy - coeliac screening
Varices: possible therapy
Other (details below)

- COLONOSCOPY or
FLEXIBLE SIGMOIDOSCOPY
Indication (Please provide details below)
PR Bleeding
Bright
Dark/mixed
FOBT
NBCSP
Iron Deficient Anaemia (attach FBE/Fe studies)
Altered bowel habit
Diarrhoea
Constipation
Known large polyp (attach report)
Abnormal imaging (attach report)
Surveillance
Previous Ca
Previous polyps
Family history Ca (details below)
Loss of weight
Other (details below)

INPATIENT/COMPLEX/THERAPEUTIC REFERRALS: Discussed with Gastro. Reg. / Consultant
As Above ERCP Balloon Enteroscopy Antegrade Retrograde PEG

Details:

- ANTI-COAG/ANTI PLATELET THERAPY:
NONE
Aspirin
Clopidogrel
Warfarin
Other
Can it be stopped?
Yes No
Yes No
Yes No
Yes No

- COMORBIDITIES (must be completed):
NONE
Cardiac:
Respiratory:
Renal:
Diabetes: Type 1 / Type 2
Vancomycin Resistant Enterococci:
Blood Borne Virus (please specify):

ALLERGIES:
NO YES

EXTRA INFO:

PLEASE FAX REQUEST SLIP TO 9076 0393. ANY ENQUIRIES PHONE 9076 0211

INCOMPLETE/INADEQUATE REFERRALS WILL BE RETURNED TO THE REFERRING DOCTOR.
PATIENTS WILL BE SENT A HEALTH QUESTIONNAIRE - ONLY WHEN COMPLETED AND
RETURNED CAN AN APPOINTMENT BE MADE.
PATIENTS MAY BE REFERRED TO ENDOSCOPY CLINIC FOR ASSESSMENT PRIOR TO PROCEDURE.