FNH33117

HEALTH

NORTHERN

Northern Health

ENDOSCOPY
NBCSP DIRECT ACCESS
COLONOSCOPY REFERRAL

AFFIX PATIENT IDENTIFICATION LABEL HERE

U.R. NUMBER: _____

SURNAME: _____

GIVEN NAME: _____

DATE OF BIRTH: _____ SEX: _____

Referral Information:

Referring to: Request for colonoscopy due to a positive Faecal Occult Blood Test (FOBT) as part of National Bowel Cancer Screening Program (NBCSP).

Patient Details:

Name:_____ DOB: _____ Age: _____ Gender: _____

Address:_____

Suburb: _____ State: _____

Phone Number:_____ Mobile Number: _____

Medicare Number:_____ Private Health Insurance: ❑ No ❑ Yes

Interpreter Required? ❑ No ❑ Yes

Specify Language: _____

Medical Treatment Decision Maker: _____ MTDM Contact Number: _____

Medical History (Please tick all relevant):

❑ Positive FOBT with NBCSP (must attach result)

❑ Diabetes ❑ Type 1 ❑ Type 2

❑ Cardiac disease Details: _____

❑ Respiratory Disease Details: _____

❑ Renal disease eGFR: _____

❑ Other (specify): _____

❑ Weight ≥ 140 kg

❑ BMI ≥ 45

Medications:

❑ Antiplatelet drug Details: _____

❑ Anticoagulant drug Details: _____

❑ Diabetes medication oral or injectable Details: _____

❑ Other medications (or attach current meds): _____

Referring Doctor Details:

Name: _____ Designation: _____

Signature: _____ Date:_____

Phone: _____ Fax: _____

Practice Address: _____

Provider #: _____

Please fax completed referral to *Fax No. 94953510*

Referrals must include a copy of the FOBT result.

Your patient will be contacted by Northern Health by telephone to expedite a colonoscopy

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