NEW ENGLAND SURGICAL

FOBT DIRECT COLONOSCOPY REFERRAL FORM

NAME:	DATE OF BIRTH:		
MEDICARE NUMBER:	REF #: EXPIRY:		
ADDRESS:	PATIENT EMAIL:		
TELEPHONE #	INTERPRETER REQUIRED: Y/N		
MOBILE #	LANGUAGE:		

PLEASE CONFIRM THAT THE PATIENT IS PRIVATELY INSURED:

HEALTH INSURANCE:	POLICY NUMBER:	
LEVEL OF COVER:	EXPIRY:	

DID THIS PATIENT HAVE A +FOBT RESULT?	YES []	PLEASE ATTACH COPY OF REPORT AND HEALTH SUMMARY
SOURCE: NATIONAL BOWEL SCREENING PRO	OGRAM	[] OTHER []

COMPULSORY INFORMATION

WEIGHT (KG)	YES	HEIGHT (CM)	BMI	YES
PLEASE INDICATE THE FOLLOWING		INDICATE CURRENT MEDICATIONS		
HEART CONDITIONS		WARFARIN		
		INR	DATE / /	
PACEMAKER		ANTIPLATELETS		
ANGINA		ANTICOAGULANTS		
HEART DISEASE		ASPIRIN		
CVA				
TIA		OTHER ORAL ANTICOAGUALANTS?		
ARTIFICIAL HEART VALVE				
IMPLANTABLE DEFRIBILLATORS				
DIABETES		NSAIDS		
TYPE 1		IRON TABLETS		
TYPE 2				
INSULIN / SGLTII / OTHERS		ALLERGIES		
RENAL FAILIURE		SPECIFY		
If YES what is the eGFR:				
LIVER DISEASE		ЕТОН		
LAST U/E/CS (Please enclose)		CURRENT SMOKER		
LAST COLONOSCOPY WHEN?		RESULT		
FHx BOWEL DISEASE				

All public patients with a FOBT+ are dealt with directly from our rooms, we will call them immediately once we have their referral, triage, place them on a CAT1 for the patient to then submit paperwork to TRRH or GDH

For PRIVATE PATIENTS please email this form to office@NEStamworth.com.au or via Medical Objects or Fax 6702 6996.

PRACTICE STAMP AND OR DO	OCTOR SIGNATURE		