Government of Western Australia
Department of Health

Request for Direct Access Gastrointestinal Endoscopy (Adult)

CRSE V1.7

Referral for: ☐ Public Colonoscopy ☐ Public Gastroscopy (Select either one or both)

For Clinical assessment / Other procedure (e.g. ERCP, EUC) please use the CRS General Adult Outpatient form.
For guidance on referral guidelines, please refer to the Health Pathways or CRS Websites.
Patients who require immediate attention (i.e. within 7 days) should NOT be referred via the Central Referral Service - contact the Gastroenterology service at the nearest site for advice.

For referrals to WACHS hospitals, please forward directly to the relevant site.

Patient Details

First Name: **Family Name:**

Maiden Name / Alias:

Date of Birth: / /

Gender: ☐ Male ☐ Female ☐ Intersex / Indeterminate

Home: **Work:**

Mobile:

Address:

Suburb: **Postcode:**

Medicare Number: **Ref:** **Expiry:**

Indigenous Status: ☐ N/A ☐ Aboriginal ☐ Torres Strait Islander

Interpreter Required: ☐ Yes ☐ No **Language:**

Next of Kin: **Contact Number:**

Patient available at short notice (<3 days): ☐ Yes ☐ No

Indications for Referral – Must have at least one indication selected, or a description in Other Section.

Symptom duration:

☐ < 6 weeks ☐ 6 weeks to 6 months ☐ > 6 months ☐ N/A

Lower GI Indications for Endoscopy:

☐ Abnormal imaging (Lower GI – Attach Report)
☐ Change in bowel habits (Specify Below)
☐ Chronic diarrhoea
☐ Faecal mucus
☐ Lower abdominal pain
☐ Pain on defaecation
☐ Positive FOBT – Performed by NBCSP
☐ PR bleeding > 4 wks
☐ Positive FOBT – Performed by GP
☐ PR bleeding < 4 wks
☐ Sensation of incomplete evacuation
☐ Surveillance (Specify Reason and Attach Reports)
☐ Suspected inflammatory bowel disease
☐ Bloody diarrhoea with -ve stool MCS (Attach Results)
☐ Unexplained iron deficiency (Please Provide Hb & Ferritin Results)
☐ Other (e.g. Palpable Mass, Diverticulitis – Specify Below)

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Surveillance Reason (If Relevant) – Attach Reports:

☐ Colorectal cancer ☐ Family history colorectal cancer (Specify Below)

☐ Inflammatory bowel disease ☐ Polyps

Family History:

Relative 1: Age of diagnosis:

Relative 2: Age of diagnosis:

Relative 3: Age of diagnosis:

Lower GI Comments / Additional Information:

Upper GI Indications for Endoscopy:

☐ Abnormal imaging (Upper GI – Attach Report) ☐ Dysphagia

☐ Dyspepsia ☐ Haematemesis / melaena

☐ Persistent nausea and vomiting ☐ Positive coeliac serology (Attach Report)

☐ Reflux ☐ Surveillance (Barrett's)

☐ Upper abdominal pain

☐ Unexplained iron deficiency (Please Provide Hb & Ferritin Results)

☐ Other (e.g. Bloating, Weight Loss, Palpable Mass – Specify Below)

Upper GI Comments / Additional Information:

Medical History and Risk Factors

Height (cm): **Weight** (kg): (Estimate if not known)

Medical History (Select All that Apply):

☐ Bleeding disorder (Specify Below) ☐ Kidney disease – Attach recent U&E

☐ Neurological history (Specify Below) ☐ Obstructive sleep apnoea

☐ Recent surgery (Specify Below) ☐ Significant lung / airway disease

☐ Liver disease – Attach recent LFT/INR/Platelets

☐ Diabetes

☐ Insulin dependent

☐ Non-insulin dependent

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☐ Heart disease

- ☐ Implanted defibrillator in situ
- ☐ Pacemaker in situ
- ☐ Coronary stents in situ (Specify When) ☐ <1 Year ☐ >1 Year

☐ None of the above

Additional Medical History Details:

Special Considerations:

☐ Significant alcohol history ☐ Significant illicit drug history

☐ Significant mental health issues ☐ None of the above

Other / Comments:

Is the Patient taking any anti-coagulant or anti-platelet medication/s, including Aspirin?

☐ Yes ☐ No

If Yes, please specify drug and reason:

Other Medication – Please list all medications patient is currently taking, or attach summary:

Allergies / Reactions (Inc. latex, tapes, etc.):

☐ Nil known

Relevant Investigations – Please provide date and findings, or attach report:

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ASI Eligibility

The Ambulatory Surgery Initiative (ASI) aims to reduce waiting times for minor procedures. Procedures performed under the ASI are bulk billed so patients incur no out-of-pocket expenses. ASI is available to **low-risk patients with a named referral** to a participating specialist.

If your patient consents to having their procedure under ASI at one of the sites listed, please complete the section below. If this section is not completed, or the patient is deemed ineligible, the referral will be directed to the appropriate public hospital based on catchment area and service capability.

Tick all that apply:

- ☐ <75 years
- ☐ <120kg
- ☐ Medicare eligible
- ☐ Suitable for day procedure
- ☐ Free of significant co-morbidities

For participation in the ASI, **one or more** of the following ASI Consultants must be selected. Note that your patient may be seen by another specialist at the same hospital in order to expedite their treatment.

Bentley Hospital:

- ☐ Dr Chiang Siah
- ☐ Dr Kenji So
- ☐ Dr Kharim Ghanim
- ☐ Dr Marcus Chin
- ☐ Dr Melissa Jennings
- ☐ Dr Oyekoya Ayonrinde

Osborne Park Hospital:

- ☐ Dr Muna Salama
- ☐ Dr Charlie Viiala
- ☐ Dr Ian Yusoff
- ☐ Dr Nazeen Irani
- ☐ Dr Michael Wallace
- ☐ Dr Hooi Ee
- ☐ Dr Niroshan Muwanwella

Other Comments:

Referrer Details

Name:

Provider Number:

Telephone Number: **Fax Number:**

Address:

Suburb: **Postcode:**

Date:

Signature:

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Once completed, please send referral to the Central Referral Service by one of the following methods:
(Please note that for efficiency of processing your referral, our preferred method is **Secure Messaging**)

Secure Messaging	Healthlink address ID: **crefserv**
Fax	1300 365 056
Post	Central Referral Service PO Box 3462 Midland WA 6056

For referrals to WACHS hospitals, please forward directly to the relevant site.

Hospital Use Only

Triage Outcome:	**Procedure:**	**Admission Type:**	**Other Requirements:**
Category 1 ☐	Colonoscopy ☐	Same Day ☐	PAC telephone ☐
Category 2 ☐	Gastroscopy ☐	Overnight ☐	PAC in person ☐
Surveillance (Staged Cat 2) ☐	Flexi Sigmoidoscopy ☐		Anaesthetic List ☐
Date Due:_____	Other:_____ ☐		
Return to Referrer (Specify Below) ☐			
Forward to other site: ☐			

Comments:

Name: **Designation:**	**Signature:**	**Date:**