Government of **Western Australia**
Department of **Health**

Request for Direct Access Gastrointestinal Endoscopy (Adult)

Referral for:

For clinical assessment or other procedures (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 (ie. 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:

DOB:

Gender:

Address:

Suburb:

Postcode:

Home no:

Work no:

Mobile:

Medicare no:

Ref:

Expiry:

Next of Kin:

Contact no:

Interpreter required:

Language:

Indigenous status:

Patient available at short notice (<3 days):

Indications for Referral - **Must have at least one indication selected, or description under additional information.**

Symptom duration:

Lower GI Indications for Endoscopy:

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

Surveillance Reason (If Relevant) - Attach Reports:

- ☐ Colorectal cancer
- ☐ Inflammatory bowel disease
- ☐ Family history colorectal cancer (Specify Below)
- ☐ 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)
- ☐ Dyspepsia
- ☐ Persistent nausea and vomiting
- ☐ Upper abdominal pain
- ☐ Unexplained iron deficiency (Please Provide Hb & Ferritin Results)
- ☐ Haematemesis/ melaena
- ☐ Dysphagia
- ☐ Surveillance (Barrett's)
- ☐ Reflux
- ☐ Positive coeliac serology (Attach Report
- ☐ 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)
- Recent surgery (Specify Below)
- Significant lung/airway disease
- Obstructive sleep apnoea
- Liver disease - Attach recent LFT/INR/ Platelets
- Diabetes — Type:
- Heart Disease
- Pacemaker in situ
- Implanted defibrillator in situ
- Cardiac 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

Other / Comments:

Is the Patient taking any anti-coagulant or anti-platelet medications/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:

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 old
- ☐ Medicare eligible
- ☐ Suitable for a day procedure
- ☐ <120 kg
- ☐ 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.

Osborne Park Hospital

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

Bentley Hospital

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

Other Comments:

Referrer Details

Name
Provider No.

Telephone No.
Fax No.
Address

Date

Signature:

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

Hospital Use Only			
Triage Outcome Category 1 ☐ Category 2 ☐ Surveillance (Staged Cat 2) ☐ Date due: _____ Return to referrer (specify below) ☐ Forward to other site: ☐ _____	**Procedure** Colonoscopy ☐ Gastroscopy ☐ Flexi sigmoidoscopy ☐ _____ ☐	**Admission Type** Same day ☐ Overnight ☐	**Other requirements** PAC telephone ☐ PAC in person ☐ Anaesthetic list ☐
Comments:			
Name: Designation:	Signature:	Date:	