



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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Surname:

First Name:

DOB:

Surveillance Reason (If Relevant) – Attach Reports:

- | | |
|---|---|
| <input type="checkbox"/> Colorectal cancer | <input type="checkbox"/> Family history colorectal cancer (Specify Below) |
| <input type="checkbox"/> Inflammatory bowel disease | <input type="checkbox"/> 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:

- | | |
|---|--|
| <input type="checkbox"/> Abnormal imaging (Upper GI – Attach Report) | <input type="checkbox"/> Dysphagia |
| <input type="checkbox"/> Dyspepsia | <input type="checkbox"/> Haematemesis / melaena |
| <input type="checkbox"/> Persistent nausea and vomiting | <input type="checkbox"/> Positive coeliac serology (Attach Report) |
| <input type="checkbox"/> Reflux | <input type="checkbox"/> Surveillance (Barrett's) |
| <input type="checkbox"/> Upper abdominal pain | |
| <input type="checkbox"/> Unexplained iron deficiency (Please Provide Hb & Ferritin Results) | |
| <input type="checkbox"/> 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):

- | | |
|--|---|
| <input type="checkbox"/> Bleeding disorder (Specify Below) | <input type="checkbox"/> Kidney disease – Attach recent U&E |
| <input type="checkbox"/> Neurological history (Specify Below) | <input type="checkbox"/> Obstructive sleep apnoea |
| <input type="checkbox"/> Recent surgery (Specify Below) | <input type="checkbox"/> Significant lung / airway disease |
| <input type="checkbox"/> Liver disease – Attach recent LFT/INR/Platelets | |
| <input type="checkbox"/> Diabetes | |
| <input type="checkbox"/> Insulin dependent | |
| <input type="checkbox"/> 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 GPO Box 2566 St Georges Terrace, WA 6831

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

Hospital Use Only			
Triage Outcome: Category 1 <input type="checkbox"/> Category 2 <input type="checkbox"/> Surveillance (Staged Cat 2) <input type="checkbox"/> Date Due: _____ Return to Referrer (Specify Below) <input type="checkbox"/> Forward to other site: <input type="checkbox"/>	Procedure: Colonoscopy <input type="checkbox"/> Gastroscopy <input type="checkbox"/> Flexi Sigmoidoscopy <input type="checkbox"/> Other: _____ <input type="checkbox"/>	Admission Type: Same Day <input type="checkbox"/> Overnight <input type="checkbox"/>	Other Requirements: PAC telephone <input type="checkbox"/> PAC in person <input type="checkbox"/> Anaesthetic List <input type="checkbox"/>
Comments:			
Name:	Signature:	Date:	
Designation:			