



# 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.**

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## 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):

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**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:**

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**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:

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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 old

<120 kg

Medicare eligible

Free of significant co-morbidities

Suitable for a day procedure

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 Nazneen Irani

Dr Niroshan Muwanwella

Dr Muna Salama

Dr Charlie Viiala

Dr Michael Wallace

Dr Ian Yusoff

**Bentley Hospital**

Dr Oyekoya Ayonrinde

Dr Marcus Chin

Mr Karim Ghanim

Dr Melissa Jennings

Dr Chiang Siah

Dr Kenji So

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**Other Comments:**

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**Referrer Details**

Name  
Provider No.

Telephone No.  
Fax No.  
Address

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

Hospital Use Only			
<b>Triage Outcome</b> 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"/> _____	<b>Procedure</b> Colonoscopy <input type="checkbox"/> Gastroscopy <input type="checkbox"/> Flexi sigmoidoscopy <input type="checkbox"/> _____ <input type="checkbox"/>	<b>Admission Type</b> Same day <input type="checkbox"/> Overnight <input type="checkbox"/>	<b>Other requirements</b> PAC telephone <input type="checkbox"/> PAC in person <input type="checkbox"/> Anaesthetic list <input type="checkbox"/>
Comments:			
Name: Designation:	Signature:	Date:	