CLEAR FORM

CALHN ENDOSCOPIC REQUEST FORM

Please fax the completed form to 08 6365 1978

PATIENT INFORMATION

First Name:	**Last Name:**	**Gender:** ☐ M ☐ F ☐ Other
Address:	**Suburb:**	**Post Code:**
Mobile Contact Number:	**Preferred site:** (Preference cannot be guaranteed) ☐ Either ☐ RAH ☐ TQEH	**Procedure Requested:** ☐ Colonoscopy ☐ Endoscopy
DOB (dd/mm/yyyy):		
Does the patient have capacity to consent? ☐ Yes ☐ No	☐ Interpreter required Language: _____	**Medicare Number:**

INDICATION FOR REQUEST

☐ +FOBT	Date of Abnormal result: _____
☐ Family history of Colorectal Cancer	☐ First degree relative with colorectal cancer (family member/age) _____ ☐ Familial syndromes diagnosis (family member/age) _____
☐ Polyp Surveillance ☐ Personal history of colorectal cancer or familial syndrome	Details of previous colonoscopy/polyp:
☐ Iron Deficiency Anaemia / Anaemia	Details: (Hb, Ferritin, Transferrin Saturation /dates) Vegetarian: ☐ Yes ☐ No
☐ PR Bleeding	Details:
☐ Dysphagia / Odynophagia ☐ Barrett's Surveillance / Screening ☐ Coeliac Surveillance / Screening ☐ Suspicion of/or follow up healing PUD ☐ Other	Details: (results/dates)

PATIENT HISTORY RELEVANT TO TRIAGE

Significant Medical History:

☐ None
☐ Cardiac Disease
☐ Diabetes
☐ Respiratory Disease
☐ Liver Disease
☐ Renal Disease
☐ Mobility issues
☐ Frailty/ Dementia
☐ Mental Health/Anxiety
☐ OSA
☐ Other: _____

Past Surgical History:

☐ None
☐ Cardiac/Thoracic
☐ Bowel Resection
☐ Abdominal Surgery
☐ Stoma
☐ Other: _____

Medications:

☐ Blood Thinners: (Please Specify)
_____
☐ Diabetic Medications: (Please Specify)
_____

Other:

Height: _____ Weight: _____ BMI: _____ Digital Rectal Exam Result: _____

☐ Alcohol (Please Specify)
☐ Drug Use (Please Specify)
☐ Smoking (Please Specify)
☐ Opiates (Please Specify)

Special Considerations:

Allergies:
_____

REFERRAL CHECKLIST

☐ This person is physically and mentally fit for colonoscopy/endoscopy to be considered.
☐ The procedure has been discussed with the patient; they are aware of the referral and willing to consider the procedure if recommended.

REFERRING DOCTOR

Name:	Provider #:	Telephone:
FAX:	Signature:	Date: