NEXGEN SURGICAL

FOBT DIRECT COLONOSCOPY REFERRAL FORM

NAME:	DATE OF BIRTH:
MEDICARE NUMBER:	REF # : EXPIRY:
ADDRESS:	PATIENT EMAIL:
TELEPHONE # MOBILE #	INTERPRETER REQUIRED: Y/N LANGUAGE:

PLEASE CONFIRM THAT THE PATIENT IS PRIVATELY INSURED:

HEALTH INSURANCE:	POLICY NUMBER:
LEVEL OF COVER:	EXPIRY:

DID THIS PATIENT HAVE A **+FOBT** RESULT? **YES [ ] PLEASE ATTACH COPY OF REPORT AND HEALTH SUMMARY**
SOURCE: NATIONAL BOWEL SCREENING PROGRAM [ ] OTHER [ ]

COMPULSORY INFORMATION

WEIGHT (KG)	**YES**	**HEIGHT** (CM) **BMI**	**YES**
PLEASE INDICATE THE FOLLOWING		**INDICATE CURRENT MEDICATIONS**	
HEART CONDITIONS		WARFARIN INR DATE / /	
PACEMAKER		ANTIPLATELETS	
ANGINA		ANTICOAGULANTS	
HEART DISEASE CVA TIA		ASPIRIN OTHER ORAL ANTICOAGUALANTS?	
ARTIFICIAL HEART VALVE			
IMPLANTABLE DEFRIBILLATORS			
DIABETES		NSAIDS	
TYPE 1		IRON TABLETS	
TYPE 2			
INSULIN / SGLTII / OTHERS		ALLERGIES	
RENAL FAILIURE If YES what is the eGFR:		SPECIFY	
LIVER DISEASE		ETOH	
LAST U/E/CS (Please enclose)		CURRENT SMOKER	
LAST COLONOSCOPY WHEN?		RESULT	
FHx BOWEL DISEASE			

All public patients with a FOBT+ are dealt with directly from our rooms, we will call them immediately once we have their referral, triage, place them on a CAT1 for the patient to then submit paperwork to TRRH or GDH

For PRIVATE PATIENTS please email this form to surgery@nexgensurgical.com.au or via Medical Objects or Fax 02 6766 8026.

PRACTICE STAMP AND OR DOCTOR SIGNATURE