

GASTROENTEROLOGY REFERRAL FORM

Date of referral:

Referral valid for: ☐ 12 months ☐ Indefinite

PATIENT DETAILS

First name:		Surname:	
Date of birth:		Age / Sex:	
Address:			
Home phone:		Mobile:	
Medicare no.:		Expiry:	

REQUEST

☐ Colonoscopy ☐ Gastroscopy ☐ Consultation

REASON FOR REFERRAL

☐ Symptoms ☐ Asymptomatic screening
☐ Positive FOBT or other test result ☐ Follow up surveillance
☐ Others

Clinical details / if Others, please specify:

CURRENT MEDICATIONS AND ALERTS

Allergies:

☐ Diabetes - on tablets or insulin ☐ GLP-1 receptor agonist
☐ SGLT2 inhibitors ☐ Renal impairment
☐ Anticoagulants / antiplatelets - warfarin, Plavix, Xarelto, Eliquis, other

CLINICAL DETAILS

REFERRING DOCTOR

Name:		Provider no.:	
Practice:			
Address:			
Phone:		Fax:	
Signature:		Date:	

Phone: 07 3193 0877 Fax: 07 3319 6466 reception@gisb.com.au www.gisb.com.au

For all appointments please call: 07 3193 0877