WESTMINSTER

PRIVATE OPEN ACCESS ENDOSCOPY SERVICE

REFERRAL

PATIENT DETAILS: (USE PATIENT LABEL IF PREFERRED)

Last Name:_____ First Name:_____

Address:_____

Date of birth:_____ ☐Male ☐Female

Contact: (H)_____ (W)_____ (M)_____

REQUEST FOR PROCEDURE:

☐***Gastroscopy*** ☐***Colonoscopy*** ☐***Gastroscopy & Colonoscopy***

REASON FOR REQUEST:

☐Abnormal radiology	☐Barrett's surveillance	☐GI Bleeding	☐Altered bowel habits	☐Constipation
☐Anaemia	☐Dysphagia	☐Cough	☐CRC surveillance	☐Diarrhoea
☐Pain	☐Vomiting	☐Reflux	☐Polyp surveillance	☐Rectal Bleeding
	☐Coeliac			

☐Other _____

Co-morbidities: _____

_____

Current Weight (kg): _____ **(must be less than 130kg)**

CURRENT MEDICATIONS:

☐Anticoagulants	☐Aspirin	☐Insulin	☐Other blood thinning agents
☐Warfarin	☐NSAID's	☐Iron supplements	

☐Other _____

Allergies: _____

NAME OF REFERRING DOCTOR: _____

PROVIDER NO.: _____

Address:_____

Phone No.:_____ Fax No.:_____

Referring Practitioner's Signature: Date:

Gastroenterologists: *Assoc. Professor Leon Adams & Dr Simon Hazeldine*

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