

Patient Details:

Name: _____
 DOB: _____ Gender: **M** **F**
 Address: _____

H) M)

Referral To:

- | |
|---|
| <input checked="" type="checkbox"/> Dr Mel Pretorius |
| <input checked="" type="checkbox"/> Dr John Lancaster |
| <input checked="" type="checkbox"/> Dr Nick Hammerl |
| <input checked="" type="checkbox"/> Dr Allan Smith |
| <input checked="" type="checkbox"/> |

Reason for referral:

<u>Symptoms</u>	YES	NO
Altered Bowel		
Anaemia		
PR Bleed		
Wt Loss		
<u>Investigations</u>	Attached	Requested
E/LFT		
CRP		
FOB		
Ferritin		
<u>Suggested Investigations</u>	Attached	Requested
Inflam Bowel Disease – ESR		
Abdo Pain – Ct or U/S		
Anaemia – Ferritin, B12, folate		
Diarrhoea – Stool m/c/s, TSH, celiac serology		

If requested which provider used (circle one)

QML	S&N	Gribbles	Coastal
-----	-----	----------	---------

Allergies: _____

Smoker: **Y** **N** Alcohol: _____drinks/wk **N**BMI > 35: **Y** **N**Special Circumstances:

 _____**Relevant Medical History**Previous colonoscopy? **Y** **N** Date: _____Polyps Present? **Y** **N**Was histology performed/where?

 _____Family Hx Bowel Cancer (Relationship and age of diagnosis)? _____

 _____Updated Co morbidities:

 _____Updated Medications:

GP/PRACTICE STAMP:

GP Signature:

Date: