St. Michael's Hospital

**ALL SECTIONS MUST BE FILLED OUT OR REFERRALS WILL BE RETURNED**

**ENDOSCOPY UNIT**
**St Michael's Hospital**

**Referred By:**
**Date:**

**WARD** ____________________

Name:

Address:

Date of Birth:

Telephone No:

**PUBLIC** ❑ **PRIVATE** ❑

**PROCEDURE (Tick Box)**

**CUBT(Urea breath Test)** ❑ **OGD** ❑ **COLONOSCOPY** ❑ **LEFT COLON** ❑

**INDICATIONS FOR PROCEDURE: (Tick Box)**

| | | | | | |
|---|---|---|---|---|---|
| DIARRHOEA | ❑ | ABDO PAIN (QUADRANT) | ❑ | NAUSEA | ❑ |
| CONSTIPATION | ❑ | LUQ ❑ RUQ ❑<br>LLQ ❑ RLQ ❑ | | VOMITING | ❑ |
| ALTERED BOWEL HABIT | ❑ | ANAEMIA | ❑ | HAEMATEMESIS | ❑ |
| PR BLEEDING | ❑ | WEIGHT LOSS | ❑ | REFLUX | ❑ |
| FOB POSITIVE | ❑ | BLOATING | ❑ | EPIGASTRIC PAIN | ❑ |
| HAEMORRHOIDS | ❑ | Ca SCREENING | ❑ | DYSPEPSIA | ❑ |
| MELAENA | ❑ | POST-RESECTION SURVEILLANCE | ❑ | BARRETT'S | ❑ |
| TENESMUS | ❑ | | ❑ | DYSPHAGIA | |
| POLYP SURVEILLANCE | ❑ | | | | |

**DURATION OF SYMPTOMS:** ___________WKS ___________MONTHS __________YEARS

| Patient's Name | | Date of Birth | / / |
|---|---|---|---|

IS THE PATIENT DIABETIC? YES ❑ NO ❑ TYPE 1 ❑ TYPE II ❑

IS THE PATIENT ON WARFARIN? YES ❑ NO ❑

IS THE PATIENT ON ASPIRIN/PLAVIX? YES ❑ NO ❑

INDICATION FOR ANTICOAGULANT: ______________________________

ACTION TO BE TAKEN: DISCONTINUE ❑ ____________ days prior

CONTINUE ❑

ALLERGIES: ______________________________

PAST MEDICAL HISTORY:

______________________________

______________________________

______________________________

______________________________

______________________________

INFECTION RISK/EXPOSURE YES ❑ NO ❑ DETAILS ______________________

Signed: ______________________ Contact Number: ______________

*Please Fax to 2807271 or post to the Day ward Booking Office, St. Michael's Hospital*

OFFICE USE ONLY:

RECEIVED IN ENDOSCOPY UNIT

STAMP

REVIEWED AND PRIORITISED BY ENDOSCOPY

REGISTRAR/CONSULTANT DATE ____________

OGD ❑ COLONOSCOPY ❑ LEFT-SIDE COLONOSCOPY ❑

Urgent __________ Soon __________ Routine __________

Signed ____________________

Date for procedure __________ Comments ______________________

______________________

Appointment/information sent ____________ ______________________