

DIRECT ACCESS ENDOSCOPY REFERRAL FORM



BON SECOURS HOSPITAL

Glasnevin, Dublin 9

Advanced Medicine Exceptional Care

(All fields must be completed)

Please fax completed form to 01 806 5660

REFERRER DETAILS

Name: _____

Address: _____

Tel: _____ Fax: _____

Email: _____

Signature: _____

PATIENT DETAILS

Name: _____

Address: _____

Tel: / Mobile: _____

DOB: _____

Private Health Insurance: Glo ☐ Irish Life ☐ Laya ☐ Vhi ☐

Other _____ No insurance ☐

PROCEDURE REQUESTED

Requested Consultant _____ (insert name) Next available Consultant ☐

Colonoscopy ☐ Upper GI Endoscopy ☐ Left / Sigmoidoscopy ☐

Insurance Code (455)

Insurance Code (194)

Insurance Code (450)

Please advise patient to confirm procedure code with their insurance provider

CATEGORY OF REFERRAL

Urgent ☐ Routine ☐

CLINICAL INDICATIONS FOR REQUEST

Diagnostic Colonoscopy

Iron Deficiency Anaemia ☐

Haemoccult positive stool ☐

Rectal bleeding ☐

Personal History of Adenomatous Polyp ☐

Family History of Colon Cancer (provide details) ☐

Altered bowel habit ☐

Other _____

Upper GI Endoscopy

Unexplained weight loss ☐

Iron Deficiency Anaemia ☐

GORD ☐

Dysphagia ☐

Abdominal pain ☐

Follow-up Gastric Ulcer ☐

Dyspepsia (>55 years)

- no response to PPI Yes ☐ No ☐

Duration of Symptoms _____

MEDICAL HISTORY (Please tick and complete as appropriate)

Diabetes ☐ Type 1 or 2 _____

Renal Impairments ☐ _____

Cardiac ☐ _____

Respiratory ☐ _____

Abdominal Surgery ☐ _____

Any other significant history _____

Medications incl. anticoag, insulin & anti platelet agents

Drug Allergies: _____

RECENT INFECTIOUS DISEASES eg MRSA, C diff, Hepatitis etc.