DIRECT ACCESS ENDOSCOPY REFERRAL FORM

BON SECOURS HOSPITAL DUBLIN
Advanced Medicine Exceptional Care

(All fields must be completed)
Please email the completed form to dublindirectendoscopy@bonsecours.ie

REFERRER DETAILS

Name: _____

Address: _____

_____

Tel: _____ **Fax:** _____

Signature: _____

PATIENT DETAILS

Name: _____

Address: _____

_____

Tel: / Mobile: _____

DOB:

Private Health Insurance Yes O No O

PROCEDURE REQUESTED

Requested Consultant _____ (insert name) Next available Consultant O

Colonoscopy O
Insurance Code (455)

Upper GI Endoscopy O
Insurance Code (194)

Left / Sigmoidoscopy O
Insurance Code (450)

Please advise patient to confirm procedure code with their insurance provider

CATEGORY OF REFERRAL

Urgent O Routine O

CLINICAL INDICATIONS FOR REQUEST

Diagnostic Colonoscopy

Iron Deficiency Anaemia	O
Haemoccult positive stool	O
Rectal bleeding	O
Personal History of Adenomatous Polyp	O
Family History of Colon Cancer (provide details)	O
Altered bowel habit	O

Upper GI Endoscopy

Unexplained weight loss	O
Iron Deficiency Anaemia	O
GORD	O
Dysphagia	O
Abdominal pain	O
Follow-up Gastric Ulcer	O
Dyspepsia (>55 years) - no response to PPI	Yes O No O

Other _____

MEDICAL HISTORY (Please tick and complete as appropriate)

Diabetes	O	Type 1 or 2 _____
Renal Impairments	O	_____
Cardiac	O	_____
Respiratory	O	_____
Abdominal Surgery	O	_____
Any other significant history		_____

Medications incl. anticoag, insulin & anti platelet agents

_____

_____

_____

_____

_____

Drug Allergies: _____

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

Ref: 2105028