



Patient Details

Or attach label if available

Name: DOB:

Address:

Email: Phone:

Services Required

Please tick the required service

- | | |
|--|--|
| <input type="checkbox"/> Gastroenterology or Hepatology Consultation | <input type="checkbox"/> Iron Infusion |
| <input type="checkbox"/> Fibroscan® Consultation | <input type="checkbox"/> Open Access Gastroscopy** |
| <input type="checkbox"/> Metabolic Health Consultation | <input type="checkbox"/> Open Access Colonoscopy** |

**** Patients with any of the following will require a referral for consultation prior to endoscopy:**

- Age > 70 years
- Significant cardiac or respiratory disease
- Diabetics (on oral medication or insulin)
- BMI > 40 kg/m²
- Blood thinning medication other than aspirin

Indication for Referral

Please tick the relevant indications & attach relevant supporting clinical history / investigations

- | | | |
|---|--|--|
| <input type="checkbox"/> Inflammatory bowel disease | <input type="checkbox"/> Rectal bleeding / positive FOBT | <input type="checkbox"/> Coeliac disease |
| <input type="checkbox"/> Irritable bowel syndrome | <input type="checkbox"/> Liver disease / LFT derangement | <input type="checkbox"/> Iron deficiency |
| <input type="checkbox"/> Reflux/abdominal pain | <input type="checkbox"/> Metabolic dysfunction | <input type="checkbox"/> Anaemia |

Other:

Medical Comorbidities

Please list any major co-morbidities

Referring Doctor Details

Or doctor's stamp

Doctor Name: Provider #:

Practice Name: Referral Date:

Address:

Preferred Location

Masada Hospital
26 Balaclava Rd, St Kilda East
VIC 3183

Holmesglen Private Hospital
490 South Rd, Moorabbin
VIC 3189