Gastroenterology Specialist Centre

Dr Son Le	Ph 9790 4632	Fax 9475 1161
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ENDOSCOPY SERVICES REFERRAL FORM

Dr Son Le
Suite 1, Level 1
56 Kitchener Parade
Bankstown 2200

Telephone No: 9790 4632
Facsimile No: 9475 1161

Surname:

Given Names:

DOB: **Age:**

Phone Nos: Home:
Work:

Request Gastroscopy (endoscopy) ☐ Colonoscopy ☐

Preferred location Bankstown Day Surgery ☐ Waratah Private Hurstville ☐

North Shore Private ☐

Indication _____

_____

_____

Patients with any of the following indicators <u>will not be suitable</u> for open access and will require at least a telephone consultation with a Gastroenterologist:

*** Age > 75**
*** BMI > 40**
*** CVA within 3 months**
*** Acutely ill / febrile**
*** AMI within 3 months**
*** Chronic Renal Failure**
*** Patients who have had drug eluting stents within the last 18 months**
*** Diabetic**
*** Severe Asthma / CAL**
*** TIA within 3 months**
*** Takes anticoagulants**
*** Takes clopidogrel**
*** Unstable angina**
*** Intending overseas travel within 2 weeks**

Current medications	***Dosage***

Referring Doctor:

Print Name _____ Signature:_____

Date: _____ Provider No: _____