

Direct Access Colonoscopy Form

For suitable patients

PATIENT DETAILS

Name: _____ DOB: _____

Best contact number: _____

Privately Insured: YES NO Self-funding: YES NO

INDICATION FOR COLONOSCOPY

- | | | |
|--|--|---|
| <input type="radio"/> Positive faecal occult | <input type="radio"/> Personal history of polyps | <input type="radio"/> Iron deficiency anaemia |
| <input type="radio"/> Rectal bleeding | <input type="radio"/> Family history of bowel cancer | <input type="radio"/> Other (please specify) |

MEDICAL HISTORY

If the patient suffers from any of the following conditions, they will be required to attend a separate consultation with the specialist prior to admission for their procedure.

- | | | |
|--|------------------------------|--|
| <input type="radio"/> Coronary heart disease | <input type="radio"/> Asthma | <input type="radio"/> Diabetes |
| <input type="radio"/> Atrial fibrillation | <input type="radio"/> COPD | <input type="radio"/> Renal failure |
| <input type="radio"/> Pacemaker | <input type="radio"/> OSA | <input type="radio"/> Other (please specify) |

Please identify if your patient is taking any of the following medications:

- | | |
|--|--------------------------------------|
| <input type="radio"/> Oral diabetes medication | <input type="radio"/> Anticoagulants |
| <input type="radio"/> Insulin | <input type="radio"/> Aspirin |

Please advise if the patient has any allergies:

REFERRING DOCTOR DETAILS

Please place referring doctor's stamp or signature below or seek a separate referral to be faxed through.
Without a valid referral from your GP or Specialist Medicare will not cover part of your procedure.

Date:

Signature