Colorectal SA
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Direct Access Colonoscopy Form

For suitable patients

PATIENT DETAILS

Name: _____ DOB: / /

Best contact number: _____

Privately Insured: YES / NO (Please circle) Self-funding: YES / NO (Please circle)

INDICATION FOR COLONOSCOPY

- ○ Positive faecal occult
- ○ Personal history of polyps
- ○ Iron deficiency anaemia
- ○ Rectal bleeding
- ○ Family history of bowel cancer
- ○ 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.

- ○ Coronary heart disease
- ○ Asthma
- ○ Diabetes
- ○ Atrial fibrillation
- ○ COPD
- ○ Renal failure
- ○ Pacemaker
- ○ OSA
- ○ Other (please specify)

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

- ○ Oral diabetes medication
- ○ Anticoagulants
- ○ Insulin
- ○ 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**