Triple I (Hub)
General Practitioner Referral

Health
South Western Sydney
Local Health District

GENERAL PRACTITIONER REFERRAL (must complete this section)		
PATIENT DETAILS		
Family name:	**Given Names:**	
Sex:	**Date of Birth:**	**Age:**
Address:		
Phone (H):	**Phone (W):**	**Phone (M):**
Email:		
Ethnicity / Aboriginal and Torres Strait Islander Status: **Interpreter Required:** ☐ Yes ☐ No (if yes, language spoken):		
Medicare card no: IRN: Expiry: NOTE: If Medicare ineligible, fees will apply. Contact Triple I for details.		
DVA Card Number: Card Type: NOTE: If DVA Card Holder, refer to DVA unless Hospital Avoidance category of client.		
Pension/Health Care Card No:	**Private Health Insurer:**	
Marital Status:	**Occupation:**	
Next of Kin Details: **Name:** **Relationship to Carer:** **Contact Number:** **Address:**		
REFERRING MEDICAL OFFICER'S DETAILS		
Doctor's Name:	**Provider No:**	
Phone:	**Fax:**	
Address:		
Email:		

Please fax to: 02 4621 8799 - Telephone: 1800 455 511 –

Email: SWSLHD-TripleI@health.nsw.gov.au

Version 6.4 -23/11/2022

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Clinical Details
Relevant Medical History:
Current Medications:

Referral for Positive FOBT Direct Access Colonoscopy (DAC)

SPECIALIST BEING REFERRED TO:

Please circle/nominate a Specialist:

Liverpool Clinic:	**Campbelltown Clinic:**	**Bankstown Clinic:**
☐ Dr Ken Koo (Coordinator)	☐ Dr Ian Turner (Coordinator)	☐ Dr Akalya Mahendran (Coordinator)

*If another specialist has a shorter wait time, the patient could be contacted and offered an earlier appointment. A new referral is not required.

MEDICAL HISTORY:

Weight (kg):	Height (m):
Previous colonoscopy: Y / N	If YES - year of last colonoscopy:

CURRENT SYMPTOMS:

☐ Nil	☐ Unexplained abdominal pain
☐ Iron deficiency anaemia	☐ Palpable or visible rectal/abdominal mass
☐ Unexplained weight loss	☐ Other (specify) _____
☐ Rectal bleeding	

Please tick ALL items:	YES	NO
Cardiac disease (e.g. IHD, heart failure, pacemaker, valve disease, coronary stent)		
Chronic respiratory disease (e.g. COPD, poorly controlled asthma)		
Chronic kidney disease EGFR < 60 ml/min/1.73m^2		
Cirrhosis		
Diabetes not on insulin		
Diabetes on insulin		
Obstructive sleep apnoea		
Advanced malignancy		
Impaired mobility affecting independence with bowel preparation (e.g. CVA, Parkinson's)		

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Previous history of difficulties with anaesthesia		
Please tick ALL items:	YES	NO
On anticoagulant (warfarin, apixaban, dabigatran, rivaroxaban)		
On antiplatelet other than aspirin (e.g. clopidogrel, prasugrel, ticagrelor, asasantin)		
Is the patient anaemic or iron deficient?		
Has the patient had a colonoscopy within the last 4 years?		
Previous history of difficult colonoscopy (e.g. incomplete colonoscopy, complication)		
Does patient require a specialist assessment for GI symptoms prior to colonoscopy?		
Does the patient have capacity to understand instructions of the bowel preparation and advice of the risks and benefits of a colonoscopy?		
Other issues - Please specify:		

For FOBT DAC Referrals please attach the following documents to this referral form

- ☐ **Patient Health Summary**
- ☐ **Positive FOBT result**
- ☐ **Recent blood tests – FBE, UEC, LFT, Iron studies**
- ☐ **Specialist Letters for relevant conditions**

Date:	**Doctor's signature:**

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