

RAPID ACCESS ENDOSCOPY SERVICE

DR NISHLAN PILLAY



Regional Specialists
Tamworth

Enquiries: Regional Specialists Tamworth Phone: 02 6762 2321		Send referral to: Fax: 02 82874707 Email: reception@regionalspecialists.com.au	
Patient Details *mandatory fields			
Family Name*		Given Name*	
Date of Birth*		Sex	<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Other
Address*			Telephone*
Medicare No		Reference No	Expiry
Health Insurance		Number	
<input type="checkbox"/> Gastroscopy		<input type="checkbox"/> Colonoscopy	
<input type="checkbox"/> Bleeding <input type="checkbox"/> Haematemesis / melaena <input type="checkbox"/> Iron deficient anaemia (<i>attach FBC / Fe studies</i>) <input type="checkbox"/> Dysphagia <input type="checkbox"/> Loss of Weight <input type="checkbox"/> Abnormal imaging (<i>attach report</i>) <input type="checkbox"/> Dyspepsia <input type="checkbox"/> Reflux <input type="checkbox"/> Barrett's screening <input type="checkbox"/> Small bowel biopsy – coeliac screening		<input type="checkbox"/> PR Bleeding <input type="checkbox"/> Bright <input type="checkbox"/> Dark / mixed <input type="checkbox"/> Positive FOBT <input type="checkbox"/> NBCSP <input type="checkbox"/> Iron deficient anaemia (<i>attach FBC / Fe studies</i>) <input type="checkbox"/> Altered bowel habit <input type="checkbox"/> Diarrhoea <input type="checkbox"/> Constipation: Duration _____ <input type="checkbox"/> Known large polyp (<i>attach report</i>) <input type="checkbox"/> Abnormal imaging (<i>attach report</i>) <input type="checkbox"/> Surveillance <input type="checkbox"/> Previous Ca <input type="checkbox"/> Previous polyps <input type="checkbox"/> Family history Ca <input type="checkbox"/> IBD <input type="checkbox"/> Weight Loss <input type="checkbox"/> Other (<i>list</i>): _____	
Anti-coagulation / Anti-platelet Therapy		Comorbidities	
<input type="checkbox"/> None <input type="checkbox"/> DOACs <input type="checkbox"/> Clopidogrel <input type="checkbox"/> Warfarin <input type="checkbox"/> Other Comment: _____		<input type="checkbox"/> None <input type="checkbox"/> Cardiac <input type="checkbox"/> Respiratory <input type="checkbox"/> Renal <input type="checkbox"/> Liver <input type="checkbox"/> Diabetes: <input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2 <input type="checkbox"/> Insulin <input type="checkbox"/> SLGT1 Inhibitor <input type="checkbox"/> VRE colonisation <input type="checkbox"/> Blood Borne Virus (<i>detail</i>)	
Allergies <input type="checkbox"/> Nil known <input type="checkbox"/> Yes, <i>list</i> :			
Comments			
Referrer Details			
Name		Provider No	
Address			
Phone		Fax	
Email			
Signature		Date	
Copies to			