



GENERAL PRACTITIONER REFERRAL FORM
ENDOSCOPY / GASTROENTEROLOGY

Patient Name: _____ Date of Birth: ____/____/____
Addresses: _____
Contact Telephone: _____ Patient Age: _____

Previous Endoscopy / Colonoscopy?
Date: ____/____/____ Hospital: _____
Medical Record Number: _____
Medication: Warfarin [] Clopidogrel [] Dabigatran [] MAOI []
Diabetic: No [] Insulin [] No Insulin []
Referring GP:
Address:
Telephone:

SYMPTOMS

UPPER GI
Pain []
Dyspepsia []
Reflux / Heartburn []
Dysphagia []
Haematemesis []
Melaena []
Nausea / Vomiting []
Anaemia []
Weight Loss []
Barrett's Oesophagus []
Duodenal Biopsy []
Other Indication:
COLORECTAL SYMPTOMS
Abdominal / Rectal Mass []
Iron Deficiency Anaemia []
Rectal Bleeding >6 weeks []
<6 weeks []
Loose Stools or Diarrhoea >6 weeks []
<6 weeks []
IBD Assessment []
COLORECTAL SCREENING
Average Risk (Age<50) []
History of Adenomatous Polyps []
History of Colorectal Cancer []
Family History []
IBD Surveillance []
G.P. Signature: _____
Medical Council Number: _____

HOSPITAL USE ONLY

Date Received: ____/____/____
Date Reviewed: ____/____/____ Appointment: ____/____/____
OGD [] Colonoscopy [] Left Colon [] UBT [] OPD []
Priority 1 [] Priority 2 []
Consultant Signature: _____
Medical Council Number: _____