Endoscopy Location

Hobson Healthcare
179 Princes Highway
Werribee 3030
Phone: 0481253671
admin@surfcoastendoscopy.com
www.surfcoastendoscopy.com

SURFCOAST
ENDOSCOPY SERVICES

Endoscopists

Dr. Paul Dabkowski
Provider Number: 31617CH
Dr. Shahzaib Anwar
Provider Number: 1575161F
Dr Jonathan Segal

Referral - Doctor to Complete

Select Title	Patient Details	
☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr.	First Name:	Last Name:
☐ Other:	Phone Number:	Date of Birth:
	Email:	Post Code:
	Address:	Suburb:

Patient Information	Appointment Type	Medicare and Health Care
Height (cm):	☐ Gastroscopy	Medicare Number: ☐ Yes ☐ No
Weight (kg):	☐ Colonoscopy	Health Care Card: ☐ Yes ☐ No
BMI (if known):	☐ Both Gastroscopy & Colonoscopy	Pension Card: ☐ Yes ☐ No
	☐ Other:	

Symptoms & Investigations (Tick where applicable, and add comments if "Yes")

Positive FOBT	☐ Yes	Abnormal Imaging	☐ Yes	Other Comments
Anaemia and/or Fe Deficiency	☐ Yes	Hb	☐ Yes	
Rectal bleeding, duration	☐ Yes	MCV	☐ Yes	
Change in usual bowel habit	☐ Yes	Ferritin	☐ Yes	
Diarrhoea (stool culture negative), duration	☐ Yes	Calprotectin	☐ Yes	
Unexplained abdominal pain > than 6 weeks	☐ Yes	Coeliac Serology	☐ Yes	
Unexplained weight loss?	☐ Yes	Others	☐ Yes	
Palpable Mass	☐ Yes		☐ Yes	

Clinical Indicators (Tick where applicable)

Does the Patient have Diabetes?	☐ Yes	Need assistance with walking or ADLs?	☐ Yes	Heartburn/Reflux	☐ Yes
History of stroke or blood clots?	☐ Yes	Any breathing problems?	☐ Yes	Upper Anbominal Pain	☐ Yes
Sleep apnoea or use a CPAP machine?	☐ Yes	Any anaesthetic problems in the past?	☐ Yes	Bloating	☐ Yes
Any heart problems?	☐ Yes	Any restrictions to receiving treatment?	☐ Yes	Nausea or Hiccoughing}	☐ Yes
Any virus/infections?	☐ Yes	Any Hospitalised recorde in the past 12 months?	☐ Yes	Other Comments	
Any allergic reaction to drugs/medication?	☐ Yes	Any food intolerances?	☐ Yes		
Does the patient have a latex allergy?	☐ Yes	Does the patient suffer from constipation?	☐ Yes		

Is the patient taking any of the following medication?

☐ Aspirin/Cartia ☐ Nexium ☐ Iron ☐ Blood Thinning Medication ☐ Other Medication:

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Referring Doctor's Details

Surname:	Given name:
Provider number:	
Address:	
Telephone number:	
Fax number:	
Date:	
Preferred contact: ☐ Telephone ☐ Fax ☐ Email:	

Practice stamp (if available)

Please ensure a list of all current medications is attached to this referral.
Referrals without this information will not be accepted.

I have reviewed the Exclusion Protocol located at **https://surfcoastendoscopy.com/for-doctors/** and can confirm that:

☐ The patient has a risk identified in the Surfcoast Endoscopy Exclusion Criteria (SEEC) and therefore requires a PAC to be arranged by SES period to a procedure being booked;

or

☐ The patient does not have a risk identified in the SEEC.

☐ **I have reviewed the Surfcoast Endoscopy Privacy Policy (SEPP) at www.surfcoastendoscopy.com/privacy and have obtained consent from my patient to provide this information here**

Doctor's Signature: _____ Date: ____ / ____ / ____

This form must be scanned and emailed to admin@surfcoastendoscopy.com