
Referral for Open Access Endoscopy and Colonoscopy

Fax to (08) 8364 2869

Once the referral form has been received, we will contact the patient, arrange all hospital paperwork and information sheets and book the procedure within 7-14 days.

Patient's Name	Date of Birth	Sex M / F
Address		
Telephone		

Request for:
<input type="checkbox"/> Consultation
<input type="checkbox"/> Upper GI Endoscopy
<input type="checkbox"/> Colonoscopy

Clinical Details:
Is the patient on:
<input type="checkbox"/> Aspirin
<input type="checkbox"/> Clopidogrel
<input type="checkbox"/> Warfarin
<input type="checkbox"/> Insulin or diabetic tablets

Referring Doctor's Name
Provider Number
Address
Telephone
Signature _____ Date _____