

Direct access endoscopy referral form

(All fields must be completed by referring Doctor)
Please fax completed form to 01 6459751 or email to endoscopy@hermitageclinic.ie

REFERRER DETAILS

Name: _____
Address: _____

Tel: _____ Fax: _____
Signature: _____

PATIENT DETAILS

Name: _____
Address: _____

Tel / Mobile: _____
DOB: _____
Private Health Insurance Yes No

PROCEDURE REQUESTED

Requested Consultant _____ (Insert name) Next Available Consultant

Colonoscopy

Procedure Code (455)

Upper GI Endoscopy

Procedure Code (194)

Left/ Sigmoidoscopy

Procedure Code (450)

*Please advise patient to confirm code with their insurance provider or contact Hermitage Medical Clinic Patient Accounts
01 6459802/01 6459487*

CATEGORY OF REFERRAL

Urgent Routine

CLINICAL INDICATIONS FOR REQUEST

Diagnostic Colonoscopy

Altered Bowel Habit
Personal History of Adenomatous Polyp
Rectal Bleeding
Iron Deficiency Anaemia
Family History of Colon Cancer (provide details)
Haemoccult positive stool

Other: _____

Upper GI Endoscopy

Abdominal pain
Follow up Gastric Ulcer
Unexplained weight loss
Dysphagia
GORD
Dyspepsia (>55 years)
No response to PPI Yes No

MEDICAL HISTORY (Please tick and complete as appropriate)

Diabetes Type1 or 2 _____
Renal Impairments _____
Cardiac _____
Respiratory _____
Abdominal Surgery _____
Any other significant history _____

MEDICATIONS (Including anticoag, insulin & anti platelet agents)

Drug Allergies: _____

RECENT INFECTIOUS DISEASES e.g. MRSA, C diff, Hepatitis, VRE, CRE etc.
