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 ☐

Upper GI Endoscopy

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

Other: ______________________

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.

Hermitage Medical Clinic Endoscopy Services
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