

**Open Access Gastroscopy Colonoscopy Service**

Please fax this request to (08) 6111 6723 or scan and email to info@perthgi.com

<input type="radio"/> <b>Gastroscopy</b>	<input type="radio"/> <b>South Perth Hospital</b>
<input type="radio"/> <b>Colonoscopy</b>	<input type="radio"/> <b>St John of God Mount Lawley</b>

First name: \_\_\_\_\_ Date: / / \_\_\_\_\_

Last name: \_\_\_\_\_ Referring GP: \_\_\_\_\_

Date of birth: / /  Male  Female Referring GP Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Referring GP Phone: \_\_\_\_\_

Address: \_\_\_\_\_ Referring GP provider number: \_\_\_\_\_

\_\_\_\_\_

Medicare Number: \_\_\_\_\_

Private Health Fund/DVA: \_\_\_\_\_

Private Health Fund membership number/DVA membership number: \_\_\_\_\_

<input type="radio"/> Reflux/Heartburn	<input type="radio"/> Anaemia	<input type="radio"/> Polyp Surveillance	<input type="radio"/> Other: _____
<input type="radio"/> FHx GI Malignancy	<input type="radio"/> +FOBT	<input type="radio"/> Rectal Bleeding	_____

<input type="radio"/> Heart disease	<input type="radio"/> Bleeding disorder	<input type="radio"/> Clopidogrel
<input type="radio"/> Valvular heart disease	<input type="radio"/> Other: _____	<input type="radio"/> Warfarin
<input type="radio"/> Lung disease	_____	<input type="radio"/> Rivaroxaban / Apixaban / Dabigatran
<input type="radio"/> Diabetes Mellitus	_____	<input type="radio"/> Other Antiplatelet / Anticoagulant medication: _____

(Please list) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_