

Prof. John Crowe, Consultant Gastroenterologist

# BOOK A DIRECT ACCESS ENDOSCOPY

## Patient Details

Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Tel/Mobile: \_\_\_\_\_

Insurance: \_\_\_\_\_

## Referring Doctor Details

Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Tel: \_\_\_\_\_

Fax: \_\_\_\_\_

Signature/Stamp: \_\_\_\_\_

Preferred method of contact:

Post  Fax  Email

Referrals are accepted by phone, email, fax or post

## Procedure Required [please tick]

Gastroscopy +/- U/S

Colonoscopy

Left Colonoscopy

Interventional procedure

## Reason for Referral

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Relevant Medications

\_\_\_\_\_  
\_\_\_\_\_

Is the patient on aspirin/plavix/warfarin? Yes  No

## Comorbidity

Diabetes

Cirrhosis

Immobility

MPH17003 v1 1011

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