

DIRECT ACCESS ENDOSCOPY REFERRAL FORM

Direct Access Endoscopy Clinic, 71 Eccles St., Dublin 7
Email: endoscopy@materprivate.ie Tel: 1800 222 333 Fax: 01 - 860 3967

PATIENT DETAILS

Name: _____
Address: _____

Tel: _____
Mob: _____
DOB: _____

REFERRING DOCTOR DETAILS

Name: _____
Address: _____

Tel: _____
Fax: _____
Preferred contact for urgent results:

Signature: _____

PROCEDURE REQUIRED [please tick]

Gastroscopy Colonoscopy Leftsided Colonoscopy
CONSULTANT: Next available Dr Bennett Dr Kelleher Prof MacMathuna
Please refer back to GP to initiate treatment Yes No

CLINICAL DETAILS [please tick]

IS THE PATIENT:

	Yes	No		Yes	No
On Aspirin	<input type="checkbox"/>	<input type="checkbox"/>	Diabetic	<input type="checkbox"/>	<input type="checkbox"/>
On Plavix	<input type="checkbox"/>	<input type="checkbox"/>	Renal Insufficiency	<input type="checkbox"/>	<input type="checkbox"/>
On Warfarin	<input type="checkbox"/>	<input type="checkbox"/>	Cirrhosis/Liver disease	<input type="checkbox"/>	<input type="checkbox"/>

MEDICATION/OTHER

Please enclose any recent lab results or other relevant test results

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