



# Request for Direct Access Gastrointestinal Endoscopy (Adult)

**Referral for:**

**Reason for Referral** (must select one):

If other please  
specify

For clinical assessment or other procedures (e.g. ERCP, EUS) please use the CRS General Adult Outpatient form. For guidance on referral guidelines, refer to the [HealthPathways](#) or [Referral Access Criteria](#) websites.

Patients who require immediate attention (ie. within 7 days) should **NOT** be referred via the Central Referral Service – contact the Gastroenterology service at the nearest site for advice.

**For referrals to WACHS hospitals, please forward directly to the relevant site.**

## Patient Details

First name:

Family  
Name:

Maiden Name/Alias:

DOB:

Sex:

Address:

Suburb:

Postcode:

Home no:

Work no:

Mobile:

Email:

Medicare no:

Ref:

Expiry:

Next of Kin:

Contact no:

Interpreter required:

Language:

Indigenous status:

Patient available at  
short notice (<3 days):

## Referrer Details

Name

Provider No.

Telephone No.

Fax No.

Address

Date

Signature:

**Lower GI indications for endoscopy:**

(MUST tick at least one box and attached relevant evidence/provide comment as indicated if referring for colonoscopy or referral will be returned)

Rectal bleeding (multiple occurrences or continuous) for >4 weeks (specify time and no. of episodes below)

+iFOBT where a colonoscopy has not been performed within last 2 years (attach results)

Altered bowel habit >6 weeks AND in presence of alarm symptoms (provide description and must select at least one alarm symptom below)

Altered bowel habit >6 weeks AND age>=45 (provide description)

Diarrhoea >6 weeks with negative stool culture (attach MC&S results)

Unexplained iron deficiency +/- anaemia (attach FBC results)

Mass or abnormal imaging (attach report)

After first episode of proven diverticulitis to exclude neoplasm

Surveillance procedures required within 12 months (specify reason & attach reports)

**Alarm symptoms for lower GI endoscopy:**

(informs triage- tick all that apply and attach evidence/ provide detail)

Persistent rectal bleeding

Persistent severe abdominal pain

Unexplained progressive weight loss

Unexplained iron deficiency anaemia

Bloody diarrhoea with negative stool MC&S

**Lower GI comments / evidence to support indications:**

**Upper GI Indications for Endoscopy:**

(MUST tick at least one box and attached relevant evidence/provide comment as indicated if referring for gastroscopy or referral will be returned)

Unexplained iron deficiency +/- anaemia (attach FBC results)

Unexplained recent dyspepsia AND in presence of alarm symptoms (select at least 1 alarm symptom below)

Non-responsive GORD

Persistent or recurrent (>=4 weeks) dysphagia (specify time and no. of episodes)

Mass or abnormal imaging (attach report)

Upper abdominal pain AND unexplained weight loss OR abnormal blood test (describe symptoms and attach results)

Persistent nausea/vomiting AND unexplained weight loss OR abnormal blood test (describe symptoms and attach results)

Suspected Coeliac disease with positive serology (attach results)

Known Coeliac disease with no exposure to gluten AND persistent high titres after 12 months OR in presence of alarm symptoms (select at least 1 alarm symptom below)

Pernicious anaemia (serologically diagnosed), asymptomatic at time of diagnosis (attach results)

Surveillance procedures required within 12 months or requested by previous endoscopist (specify reason and attach reports)

**Alarm symptoms for Upper GI Endoscopy:**

(informs triage- tick all that apply and attach evidence/ provide detail)

Gastrointestinal bleeding

Dysphagia

Unexplained progressive weight loss

Early satiety

Unexplained iron deficiency anaemia

**Upper GI Comments/  
evidence to support  
indications**

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**Medical History and Risk Factors**

<b>Height (cm):</b>	<b>Weight (kg):</b>	<b>(Estimate if not known)</b>	
Bleeding disorder <i>(specify below)</i>	Kidney disease <i>(Attach recent U&amp;E)</i>	Pacemaker in situ	
Neurological history <i>(specify below)</i>	Recent surgery <i>(specify below)</i>	Cardiac stents in situ	
Significant lung/airway disease	Obstructive sleep apnoea	Implanted defibrillator in situ	
Liver disease <i>(attach recent LFT/INR/platelets)</i>	Heart Disease	For any of above in situ items, specify when	
Diabetes	Previous CVA	> 1 year	<1 year
Type	None		

**Additional Medical History Details:**

**Special Considerations:**

Significant alcohol history	Significant illicit drug history	Significant mental health issues	Other social factors e.g. homeless <i>(detail below)</i>
Department of Justice patient	Nursing home patient		

**Other / Comments:**

**Is the Patient taking any anti-coagulant or anti-platelet medication/s, including Aspirin?**

Yes  No

If yes, please specify drug and reason (and include any relevant documentation from other specialists:

**Current medication:**

Please list all medications patient is currently taking, or attach summary

**Allergies / Reactions**  
(inc. latex, tapes etc.):

Nil  
known

**Relevant  
Investigations -**

Please provide date  
and findings, or attach  
report:

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**Other Comments:**

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**Once completed, please send referral to the Central Referral Service by one of the following methods:**  
(Please note that for efficiency of processing your referral, our preferred method is **Secure Messaging**)

Secure Messaging: Healthlink address ID: **crefserv**

Fax: 1300 365 056

Post: Central Referral Service, GPO Box 2566, St Georges Terrace, WA 6831

Hospital Use Only			
<b>Triage Outcome</b> Category 1 <input type="checkbox"/> Category 2 <input type="checkbox"/> Surveillance (Staged Cat 2) <input type="checkbox"/> Date due: _____ Return to referrer (specify below) <input type="checkbox"/> Forward to other site: <input type="checkbox"/> _____	<b>Procedure</b> Colonoscopy <input type="checkbox"/> Gastroscopy <input type="checkbox"/> Flexi sigmoidoscopy <input type="checkbox"/> _____ <input type="checkbox"/>	<b>Admission Type</b> Same day <input type="checkbox"/> Overnight <input type="checkbox"/>	<b>Other requirements</b> PAC telephone <input type="checkbox"/> PAC in person <input type="checkbox"/> Anaesthetic list <input type="checkbox"/>
Comments:			
Name: Designation:	Signature:	Date:	

