South Perth Hospital
Endoscopy Unit
76 South Terrace
South Perth 6151
(PO Box 726
Como WA 6952)
Tel: (08) 9368 2333
Fax: (08) 9638 2300
www.sph.org.au

ENDOSCOPY UNIT REFERRAL FORM

Referring Doctor please fax this request to 9368 2300
The patient will be contacted by the South Perth Hospital Endoscopy Unit to arrange a procedure time.
The patient must bring this original request with them on the day of the procedure.

PATIENT DETAILS

Patient Name: Date of Birth:

Address:

Post Code: Telephone:

REFERRAL TO

☐ First Available ☐ Dr Sam Galhenage ☐ Professor George Garas ☐ Dr Briohny Smith

REFERRER DETAILS

Date of referral:

Name: Provider Number: Phone:

Address:

Signature:

SERVICE REQUIRED (AVAILABLE OPEN ACCESS)

☐ GASTROSCOPY ☐ COLONOSCOPY ☐ GASTROSCOPY & COLONOSCOPY

INDICATION AND CLINICAL DETAILS

MEDICAL HISTORY

☐ Heart disease
☐ Lung disease
☐ Diabetes Mellitus
☐ Bleeding Disorder
☐ Warfarin
☐ Aspirin
☐ Anti-inflammatory drugs
☐ Other blood thinning medications
☐ Other: _____

ALLERGIES *(please list)*

MEDICATION LIST *(please complete)*

OFFICE USE ONLY

Does the patient weigh < 140kg: ☐ Yes ☐ No
Has the patient been hospitalised outside WA in the last 12 months: ☐ Yes ☐ No
Procedure date: ..... /..... /..... Procedure time:
Information Pack sent: ..... /..... /.....