**Aurora Melbourne Central**
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# Open Access Endoscopy Referral Form

## Patient information

**Patient Name:** _____

**D.O.B** __ __ /__ __ /__ __ **Contact Number** __ __ __ __ __ __ __ __ __ __ **Email:** _____

**Address:** _____

## Clinical information

**Procedure Requested:** Colonoscopy ☐ Gastroscopy ☐ Capsule Endoscopy ☐

**Reason for Referral:** _____

_____

**Endoscopist Requested:** Dr Suresh Sivanesan ☐ A/ Prof Jason Tye- Din ☐

## Procedural Risk Factors

**Cardio- respiratory disease:** _____

**Diabetes mellitus:** _____

**Anti-coagulants or Anti platelets:**(Note: aspirin 100mg can be continued). _____

## Referrers Details

**Name of referrer:** _____ **Provider Number:** __ __ __ __ __ __ __ __

**Address/ Practice:** _____Email _____

**Phone** __ __ __ __ __ __ __ __ __ __ **Fax:** __ __ __ __ __ __ __ __ __ __ **Referrers Signature**_____

**Please return the form by fax 03-9415 1069 or email: admin@thecms.com.au**