Northern Suburbs Gastroenterology

Referrals for Advanced Procedures

Items marked * indicate mandatory fields

Procedure requested*

- ◯ **Endoscopic Ultrasound**
- ◯ **Endoscopic Retrograde Cholangiopancreatography**
- ◯ **Percutaneous Endoscopic Gastrostomy**
- ◯ **Video Capsule Endoscopy**
- ◯ **Other** (please specify) _____

Doctor referral directed to*

Patient details

Title* First name* Last name*

Preferred name Date of birth* / /

Mobile/home phone* Email address*

Referrer details

Referring doctor* Provider number*

Clinic/postal address Postcode

Phone* Email

Preferred form of communication ◯ Argus ◯ Healthlink ◯ Email ◯ Mail

Reason for referral*

Background medical history

Patient medications*

Is the patient on anti platelets or anticoagulants? ◯ Yes ◯ No

Is the patient on diabetic medications? ◯ Yes ◯ No

Please specify/other medications

Other relevant information

Please fax/email form to (02) 8209 4856/admin@nsgastro.com.au and give original to patient. This form is available at *www.nsgastro.com.au/advanced-procedure-referrals/* as a downloadable PDF. It can also be submitted online. Patient will be contacted by practice nurse within 2-3 business days.

Suite G07, Parkway San Clinic, 172 Fox Valley Road, Wahroonga NSW 2076 PO Box 498, Wahroonga NSW 2076
Bookings: (02) 8921 9188 Fax: (02) 8209 4856 admin@nsgastro.com.au **nsgastro.com.au**