Direct access endoscopy referral form

BLACKROCK HEALTH
HERMITAGE CLINIC

(All fields must be completed by referring Doctor)
Please fax completed form to 01 6459751 or email to endoscopy@hermitageclinic.ie

REFERRER DETAILS

Name: _____
Address: _____
_____
Tel: _____ Fax: _____

Signature: _____

PATIENT DETAILS

Name: _____
Address: _____
_____
Tel / Mobile: _____
DOB: _____
Private Health Insurance Yes ☐ No ☐

PROCEDURE REQUESTED

Requested Consultant _____ (Insert name) Next Available Consultant ☐

Colonoscopy ☐
Procedure Code (455)

Upper GI Endoscopy ☐
Procedure Code (194)

Left/ Sigmoidoscopy ☐
Procedure Code (450)

Please advise patient to confirm code with their insurance provider or contact Hermitage Medical Clinic Patient Accounts 01 6459802/01 6459487

CATEGORY OF REFERRAL

Urgent ☐ Routine ☐

CLINICAL INDICATIONS FOR REQUEST

Diagnostic Colonoscopy

- Altered Bowel Habit ☐
- Personal History of Adenomatous Polyp ☐
- Rectal Bleeding ☐
- Iron Deficiency Anaemia ☐
- Family History of Colon Cancer (provide details) ☐
- Haemoccult positive stool ☐

Upper GI Endoscopy

- Abdominal pain ☐
- Follow up Gastric Ulcer ☐
- Unexplained weight loss ☐
- Dysphagia ☐
- GORD ☐
- Dyspepsia (>55 years) ☐
- No response to PPI Yes ☐ No ☐

Other: _____

MEDICAL HISTORY (Please tick and complete as appropriate)

Diabetes ☐ Type1 or 2 _____
Renal Impairments ☐ _____
Cardiac ☐ _____
Respiratory ☐ _____
Abdominal Surgery ☐ _____
Any other significant history _____
_____

MEDICATIONS (Including anticoag, insulin & anti platelet agents)

_____
_____
_____
_____
_____

Drug Allergies:_____

RECENT INFECTIOUS DISEASES e.g. MRSA, C diff, Hepatitis, VRE, CRE etc.

Hermitage Medical Clinic Endoscopy Services
Old Lucan Road
Dublin 20

Mon-Fri: 7am - 8pm
Tel: 01 6459019
Email: endoscopy@hermitageclinic.ie
www.hermitageclinic.ie