BLACKROCK HEALTH

BLACKROCK CLINIC

Cystoscopy Direct Access Referral

PATIENT DETAILS

Name _____

Date of Birth _____

Address _____

_____

_____

Telephone _____

Mobile _____

GP DETAILS

Name _____

Date of Birth _____

Address _____

_____

_____

Telephone _____

Mobile _____

Priority ☐ URGENT ☐ SOON ☐ ROUTINE

Medical Insurance ☐ VHI ☐ IRISH LIFE ☐ QUINN ☐ OTHER ☐ SELFPAY

CYSTOSCOPY INDICATIONS

Haematuria ☐ Micro-haematuria ☐

Duration of Symptoms _____

Past Medical History _____

Current Medications _____

Is the patient medically fit for bowel preparation ☐ Yes ☐ No ☐ N/A

Is patient on ☐ Warfarin ☐ Aspirin ☐ Plavix ☐ Xarelto ☐ Pradaxa

Is the patient on any other blood thinners?

Indication for treatment

Is the patient Diabetic? ☐ NO ☐ YES Is the patient on Insulin? ☐ NO ☐ YES

Has the patient had Cardiac Surgery / Valve Surgery? _____

GP Signature _____ Date _____

ENQUIRIES: daycare.unit@blackrock-clinic.com PLEASE FAX to : 01 2064532

Please Note –The following patients should be referred directly to the consultants secretary:
Patients over the age of 75 years · Patients with a significant cardiac history · Diabetic patients on Insulin therapy