Latrobe Regional Hospital

DIRECT REFERRAL
National Bowel Cancer Screening Program

MR NUMBER.....

SURNAME.....

GIVEN NAMES.....

DATE OF BIRTH..... Sex: M F
Please fill in if no Patient Label available

The following Patient has been identified as having a positive Faecal Occult Blood Test (FOBT) result as part of the National Bowel Cancer Screening Program and requires a Colonoscopy within 30 days from the date hereof

PATIENT DETAILS:

PATIENT NAME: _____

PATIENT ADDRESS: _____

_____ **POST CODE:** _____

HOME CONTACT NUMBER: _____ **MOBILE NUMBER:** _____

Date of Birth ____/____/____ ☐ Male ☐ Female **Previous Patient of LRH:** ☐ Yes ☐ No

Interpreter required ☐ Yes ☐ No Language: _____

Medicare: __ __ __ __ __ __ __ __ __ __ __ Expiry Date / /

Next of Kin / Person to be contacted in the event of an emergency

Name _____ Relationship _____ Phone _____

PATIENT DISCHARGE REQUIREMENTS:

☐ Lives with responsible Adult ☐ Lives alone ☐ Residential Care Accommodation ☐ Transport arranged
(please note patient must arrange transport home and someone to be with them post discharge or risk cancellation)

REFERRING PRACTITIONER DETAILS:

Referring GP _____
(Print name)

Clinic: _____

Signed _____ Date ____/____/____

☐ **RESULTS FROM NBCSP WITH +VE FOBT RESULT ATTACHED** (please note failure to attach results will not allow the Hospital to proceed with request for admission)

PATIENT ACKNOWLEDGEMENT FOR PLACEMENT ON WAITING LIST:

I _____ consent to being placed on the Latrobe Regional Hospital Waiting List for a COLONOSCOPY under the National Bowel Cancer Screening Program. I acknowledge that I will be treated by a Doctor nominated by the Hospital and my procedure will occur within 30 days from the day this request is received by the Hospital

Signed _____ Date ____/____/____

HOSPITAL USE ONLY

MRN		**Preadmission**	
DATE REFERRAL RECEIVED		**Phone review**	
PLACED ON WAITING LIST		**Appointment**	

PROPOSED DATE OF PROCEDURE

PROPOSED CONSULTANT

DIRECT REFERRAL – NATIONAL BOWEL CANCER SCREENING PROGRAM

DIRECT REFERRAL – NATIONAL BOWEL CANCER SCREENING PROGRAM – RISK ASSESSMENT

Latrobe Regional Hospital

DIRECT REFERRAL
National Bowel Cancer Screening Program
Risk Assessment

MR NUMBER.....

SURNAME.....

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DATE OF BIRTH..... Sex: M F
Please fill in if no Patient Label available

Please note Patients may not be considered for waiting list unless all details are COMPLETED

Weight _____ kgs Height _____ cms BMI _____

COMORBIDITIES & KNOWN ALERTS (must be completed):

	YES	NO	COMMENTS
CARDIAC			
RESPIRATORY			
RENAL			
DIABETES ☐ **TYPE 1** ☐ **TYPE 2**			
MUSCULOSKELETAL			
INFECTIOUS STATUS e.g., MRSA, VRE			
LATEX ALLERGY			

ALLERGIES/SENSITIVITIES/INTOLERANCE – medications, tapes or lotions. Please specify:

OTHER:

Can the patient continue **antiplatelet** or **anticoagulant** therapy preoperatively? ☐ YES ☐ NO - please advise:

☐ NONE ☐ ASPIRIN ☐ CLOPIDOGREL ☐ WARFARIN ☐ OTHER_____

NOTES:

MEDICATIONS: *Please outline any medications that you are currently taking including over the counter medications (including herbal remedies), pain killers and puffers. (PLEASE ATTACH MEDICATIONS LIST IF REQUIRED)*

NAME OF MEDICATION	DOSAGE	HOW OFTEN TAKEN

Please forward completed referral to Latrobe Regional Hospital Patient Services Unit:

1 ***Email*** PatientServices@lrh.com.au or,
2 ***Fax*** 5173 8445 or,
3 ***Address*** Patient Services Unit, Latrobe Regional Hospital, P.O. Box 424, Traralgon, VIC 3844