**REFERRAL TO GASTROENTEROLOGY OUTPATIENT CLINIC**

* **Please fax or email this referral to (02) 8738 3094 or** **SWSLHD-LiverpoolGastro@health.nsw.gov.au**
* **Please enter all details and provide relevant attachments. If referral is not complete, appointment allocation may be delayed.**

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| **New referral (patient not known to our service) 🞏 OR Re-referral (patient known to our service) 🞏**  |

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| **Referring Doctor details (complete or stamp)** |
| Name:  |  |
| Provider number: |  |
| Practice name & address:  |  |
| Phone: | Fax: | Email: |

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| Notify of patient appointment details Y 🞏 N 🞏 | Notify if patient does not attend appointment Y 🞏 N 🞏 |

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| **Patient details (complete or affix sticker)** |
| Surname: | Given name: |
| Date of Birth: | Sex: Male 🞏 Female 🞏 |
| Address:  |  |
| Medicare Number:  |  |
| Phone: |  | Email: |

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| **Referral Details (ensure all sections are completed)** |
| Reason for referral/current problem:  |  |
| Past Medical History: |   |
| Current Medications:  |  |
| Allergies: |  |
| Phone: | Fax: | Email: |

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| **Please include all previous investigations reports**  |
| □ Blood / stool tests |
| □ Endoscopy |
| □ Imaging  |
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