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| liv_logo_new | DEPARTMENT OF GASTROENTEROLOGY AND LIVEROutpatient Clinic E 123, Clinical BuildingLiverpool HospitalPhone (02) 8738 4085 Fax (02) 8738 3094Email: SWSLHD-LiverpoolGastro@health.nsw.gov.au  | **nswhealth_sws_lhd** |

Dear Doctor,

Faecal Occult Blood Test (FOBT) screening for bowel cancer saves lives. The National Bowel Cancer Screening Program (NBCSP) now invites your patients (50 -74yrs) to participate in the screening program using Immunochemical FOBT biennially. Safe, accurate and timely access colonoscopy to investigate positive FOBT will improve patient outcomes from bowel cancer.

The Gastroenterology Department at Liverpool Hospital will now deliver **Direct Access Colonoscopy** service to your patients who return a positive FOBT. The Gastroenterology Department will provide a high quality, patient-centred colonoscopy service which is supported by a FOBT nurse, Gastroenterologists, anaesthetic and nursing expertise. We aim to perform the colonoscopy within 6 weeks from the referral date.

With **Direct Access Colonoscopy,** only carefully selected patients with minor health problems will proceed directly to their colonoscopy without needing an initial Specialist consultation. Patients with significant co-morbidities will need a Specialist review prior to colonoscopy, as per current practice.

The steps are outlined below:

1. Inform your patient of the positive FOBT and recommend a colonoscopy. Ensure that they are willing to attend this test without an initial specialist consultation, and that they do not have gastrointestinal symptoms that require prior assessment.
2. Complete the referral form. **PLEASE FAX REFERRAL, RECENT BLOOD TESTS (FBE, UEC, LFT, IRON STUDIES) PATIENT HEALTH SUMMARY AND FOBT RESULTS to 87383094**
3. The referral form will be reviewed to determine if your patient is suitable for **Direct Access Colonoscopy** – you may be contacted for more information.
4. Patients who are suitable for **Direct Access Colonoscopy** will be directly contacted by our FOBT nurse to discuss the nature of the procedure including bowel preparation, completing the admission form and scheduling of the procedure. Patients deemed not suitable for Direct Access Colonoscopy will be scheduled a consultation date with a specialist in the clinic.
5. Your patient will see you after the colonoscopy to discuss the results and subsequent follow-up plan.
6. For more information, please contact DAC team on 0459817160 or 87387939.

**POSITIVE FOBT DIRECT ACCESS COLONOSCOPY REFERRAL FORM**

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**Please nominate one of our Specialists - A/Professor Miriam Levy, A/Professor Susan Connor, Dr Scott Davison, Dr Nishita Jagarlamudi, Dr Ken Koo, Dr Watson Ng, Dr Emilia Prakoso, Dr David Prince or Dr Astrid Williams.**

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| **PATIENT DETAILS**  |
| Name:  | Tel No (H): Tel No (MB):  |
| DOB: Sex: M / F  | Medicare No: Exp:  |
| Address:   | Interpreter required: Y / N If YES – language:  |
| **MEDICAL HISTORY**  |
| Weight (kg):  | Height (m):  |
| Previous colonoscopy: Y / N  | If YES - year of last colonoscopy:  |
| Medications:   |
| **Please tick ALL items**  | **Y**  | **N**  |
| Cardiac disease (e.g. IHD, heart failure, pacemaker, valve disease, coronary stent)  |   |  |
| Chronic respiratory disease (e.g. COAD, poorly controlled asthma)  |   |  |
| Chronic kidney disease EGFR < 60 ml/min/1.73m2  |   |  |
| Cirrhosis  |   |  |
| Diabetes on insulin  |   |  |
| Obstructive sleep apnoea  |   |  |
| Advanced malignancy  |   |  |
| Impaired mobility affecting independence with bowel preparation (e.g. CVA, Parkinson’s)  |   |  |
| Previous history of difficult colonoscopy (e.g. incomplete colonoscopy, complication)  |   |  |
| Previous history of difficulties with anaesthesia  |   |  |
| On anticoagulant (warfarin, apixaban, dabigatran, rivaroxaban)  |   |  |
| On antiplatelet other than aspirin (e.g. clopidogrel, prasugrel, ticagrelor, asasantin)  |   |  |
| Does patient requires a specialist assessment for GI symptoms prior to colonoscopy?  |   |  |
| Is the patient anaemic or iron deficient?  |   |  |
| Referring Doctor: Provider Number: Address:  Tel No: Fax No:  | Doctor’s signature:    Date:  |
| **PLEASE FAX REFERRAL, RECENT BLOOD TESTS (FBE, UEC, LFT, IRON STUDIES)**  **PATIENT HEALTH SUMMARY AND FOBT RESULTS to 87383094**  |