Tel: (01) 809 3078
Fax: (01) 809 3090

BEAUMONT HOSPITAL

STEPHEN DOYLE ENDOSCOPY UNIT - GP REFERRAL

Patient Name:_____

Address:_____

_____

D.O.B: ___/___/_____ Telephone:_____

G.P:_____

Address:_____

_____

Telephone:_____

Date of Request: ___/___/_____

Medical Insurance VHI ❑ Aviva ❑ Laya ❑ Other ❑ None ❑

Does the patient take any **ANTICOAGULANTS** Yes ❑ Please specify_____

Does the patient take any **ANTIPLATELETS** Yes ❑ Please specify_____

No **ANTICOAGULANTS** ❑ No **ANTIPLATELETS** ❑

ICD Yes ❑ No ❑

Pacemaker Yes ❑ No ❑

Is the patient Diabetic? No ❑ Insulin dependent ❑ Non Insulin dependent ❑

Specific risks? Yes ❑ No ❑ MRSA ❑ C.Diff ❑ V.R.E. ❑ C.R.E. ❑ Other ❑

Procedure Required: OGD ❑ Colonoscopy ❑ Left Colon ❑

GASTROSCOPY INDICATION

- Pain/Dyspepsia ❑
- Heartburn/Reflux ❑
- Atypical Dyspepsia ❑
- Dysphagia ❑
- Haematemesis/Melaena ❑
- Nausea/Vomiting ❑
- Anaemia ❑
- Barrett's Oesophagus ❑
- Duodenal biopsy ❑
- Epigastric Pain ❑

COLONOSCOPY INDICATION

DIAGNOSTIC

Iron deficiency anaemia ❑

Please confirm Haemoglobin ☐

Ferritin ☐

Transferrin Saturation ☐

Rectal mass ❑

Rectal bleeding (>6 weeks) ❑

Altered bowel habit (loose stools or diarrhoea) ❑

SCREENING OR SURVEILLANCE

History of adenomatous polyps ❑

History of colon cancer ❑

Family history of colon cancer/polyps ❑

Details

Other Indication: _____

HOSPITAL OFFICE USE ONLY

DATE / APPOINTMENT	DATE / APPT.	DATE / APPT.	DATE / APPT.

MR682D