Dr Robert Winn
Colorectal Surgeon

Referral for Easy Access ☐**Colonoscopy** ☐**Gastroscopy**

Title:_____ **First Name:**_____

Surname:_____

Address:_____

Suburb:_____ **Postcode:**_____

Phone **Home:**_____

Work:_____

Mobile:_____

Health Fund:_____

Medicare Number:_____ **Expiry Date:**_____

The reasons for colonoscopy and/or gastroscopy:

1.	Bleeding or mucous per rectum	☐No	☐Yes
2.	Faecal Occult Blood Test positive	☐No	☐Yes
3.	Personal or Family History of:		
	Colon Cancer	☐No	☐Yes
	Polyps	☐No	☐Yes
	Inflammatory bowel disease	☐No	☐Yes
4.	Change in bowel habit	☐No	☐Yes
5.	Abdominal pain	☐No	☐Yes
6.	Reflux	☐No	☐Yes
7.	Other? Please specify		

_____

Please fill in below OR include a Patient Summary

Medications (list all prescription drugs):

Name	Dose	Frequency

Medical History:

Heart problems: ☐high blood pressure ☐ischaemic heart disease

Lung problems: ☐asthma ☐emphysema ☐cough with sputum

Kidney problems: ☐renal impairment ☐failure

Diabetes: ☐No ☐Diet control ☐Tablet control ☐On insulin

Clotting / Bleeding problems: ☐No ☐Yes

Any cancers: ☐No ☐Yes

Specify:_____

Arthritis: ☐No ☐Yes

Past Hospitalisations and Surgical Procedures within 1 year:

_____

_____

Other illnesses:_____

Allergies:_____

Referring Doctor:_____

Provider Number:_____

Signature:_____ Date:_____

Please send by fax - 02 4229 3570, or email to info@drrobertwinn.com.au OR
mail to Easy Access Colonoscopy, PO Box 7104, Gwynneville, 2500