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 drwinncolorectal@gmail.com OR
mail to Easy Access Colonoscopy, PO Box 7104, Gwynneville, 2500