JOLIMONT ENDOSCOPY

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CAPSULE ENDOSCOPY REFERRAL FORM

PATIENT NAME D.O.B.

ADDRESS

PHONE MEDICARE NO _____ /__ EXP __ /__

CLINICAL DETAILS

INDICATION ☐ Recurrent Anaemia

☐ Persistent Bleeding ☐ Other _____

CRITERIA

PRIOR GASTROSCOPY	☐ Yes	☐ No	
PRIOR COLONOSCOPY	☐ Yes	☐ No	
PILLCAM WITHIN 12 MONTHS	☐ Yes	☐ No	Date _____

POTENTIAL CONTRAINDICATIONS

Previous bowel obstruction	☐ Yes	☐ No
Small bowel Crohns	☐ Yes	☐ No
Swallowing difficulties	☐ Yes	☐ No
Pregnant	☐ Yes	☐ No

RELEVANT MEDICAL HISTORY AND MEDICATIONS:

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REFERRING DOCTOR

NAME

PROVIDER NUMBER

PHONE

ADDRESS

SIGNATURE DATE

COPIES TO

A consultation with A/Professor BROWN may be required before the procedure.

(Jolimont Endoscopy staff will advise patient if this is necessary)