



**NEWCASTLE**  
**ENDOSCOPY**  
CENTRE

ABN 68 142 675 965



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Patient Name <PtName>

DOB <PtDoB>

Address <PtAddress>

Home Phone <PtPhoneH>

Mobile No <PtPhoneMob>

**Dr's Name:** *Please Tick*  
<Choose an item.>

**Important**

Patients who are physically fit with clear indications for colonoscopy are suitable for open access.

Patients who **do not** meet this criteria:

- are frail, symptomatic or unwell
- are over the age of 74 and under the age of 16
- have multiple chronic medical issues
- poor mobility
- BM over 40

Please include brief health summary and copy of any relevant results

Referring Doctor <Choose One>

Provider Number <DrProviderNo>

Signature

Date <TodaysDate>

\* Please fax the referral to 4947 6010, or Phone 4947 6000, or bring to Newcastle Endoscopy Centre at the address below.

\* Any questions please call the Newcastle Endoscopy Centre 4947 6000

**What happens next?**

Once Newcastle Endoscopy Centre has received this Referral form, the patient will be given further information in relation to the bowel preparations and the procedure dates.

Phone: (02) 4947 6000 (02) 4947 6010

Email: info@newcastleendoscopy.com.au

Level2, 20-22 Smith Street Charlestown 2290 | PO Box 545 Charlestown NSW 2290

[www.newcastleendoscopy.com.au](http://www.newcastleendoscopy.com.au)