NEWCASTLE ENDOSCOPY CENTRE

ABN 68 142 675 965

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
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www.newcastleendoscopy.com.au