Rapid Access – Positive Faecal Occult Blood Test Clinic Referral

Department of Gastroenterology and Hepatology

Health
Nepean Blue Mountains
Local Health District

Nepean Hospital Medical Outpatients Level 1 West Block/Building C, Derby St Kingswood
Gastroenterology CNC Monday to Friday 0830 – 1600
Ph: 4734 1763 Option 1 Mobile: 0475 426 219 Fax: 4734 2963 Email: NBMLHD-Medicalreferrals@health.nsw.gov.au

Blue Mountains District ANZAC Memorial Hospital Woodlands Rd, Katoomba
Ph: 4784 6552 Fax: 4784 6983 Email: NBMLHD-BMTDH-OutpatientClinics@health.nsw.gov.au

SECTION 1: Specialists available in this Department *(Note: Referred doctor may not be the proceduralist)*		
Nepean Clinic	☐ A/Prof Martin Weltman *MB BcH, FRACP, Phd* ☐ Dr Calvin Chan *MBBS,B Sc(Med) MClin Tres, FRACP* ☐ Dr Jim Kalantar *MBBS, MMedSc, FRACP* ☐ Nepean Gastroenterology Clinic	☐ Dr Rahim Daneshjoo *MD, FRACP* ☐ Dr Jeff Chang *MBBS, BSc(Med), FRACP, Phd* ☐ Dr Xian-Jun Mah *BBioMedSc, MBBS, FRACP*
Blue Mountains Clinic	☐ Dr Deniz Durmush *MBBS, FRACP*	☐ Blue Mountains Gastroenterology Clinic

ALL OUR SPECIALISTS BULK BILL DIRECTLY TO MEDICARE

SECTION 2: Patient Details/Sticker label		MRN:
Family Name:	Given Name:	Date of Birth:
Address:		Sex:
		Medicare No.:
Interpreter required? ☐ No ☐ Yes		Language spoken, if other than English:
Is this person: ☐ Aboriginal	☐ Torres Strait Islander	
☐ Not Aboriginal or Torres Strait Islander	☐ Aboriginal and Torres Strait Islander	

SECTION 3: Clinical Information

Reason for referral: ***Positive FOBT***

FOBT Source: ☐ National Bowel Cancer Screening Program	Date received result:
☐ Arranged by GP-please specify:	☐ Other:

Smoker: ☐ No ☐ Yes **Allergies:** ☐ Nil ☐ Allergy:

Medical History: Does the patient have the following signs or symptoms? *Please tick all items*

Overt rectal bleeding	☐ Yes	☐ No	Cardiac disease	☐ Yes	☐ No
Iron deficiency Anaemia	☐ Yes	☐ No	On anticoagulants or antiplatelets (other than aspirin)	☐ Yes	☐ No
Unexplained weight loss	☐ Yes	☐ No	Diabetes on insulin, metformin or SGLT2 inhibitors	☐ Yes	☐ No
Unexplained abdominal pain	☐ Yes	☐ No	Family history with Colorectal cancer	☐ Yes	☐ No
Altered bowel habits	☐ Yes	☐ No	Chronic kidney disease details including eGFR	☐ Yes	☐ No
Palpable or visible rectal mass	☐ Yes	☐ No	Chronic respiratory disease	☐ Yes	☐ No
If yes to any, please specify:			Cirrhosis	☐ Yes	☐ No

Any significant gastrointestinal symptoms or signs, please specify:

Mandatory Checklist –***Referral cannot be processed without the following documents attached***:

☐	Health Summary including current medications	☐	Recent blood test results (FBC, EUC, Iron Studies)
☐	Positive Faecal Occult Blood Test result	☐	Last Endoscopy/Colonoscopy Report and histopathology (If previously performed)

SECTION 4: Referring Doctor	*Practice Stamp*
Name/Provider Number:	
Practice:	
Date: Signature:	

SECTION 5: *HOSPITAL USE ONLY*				
Accepted for RAC-FOBT?	☐ Yes	☐ No	**Yes** - Procedure date:	**No** - Clinic Date: