Centre for Digestive Diseases
The Centre of Excellence in Gastroenterology

REFERRAL

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ABN: 54 097 085 884

Date of Referral: _____ DOB: _____

First Name: _____ Last Name: _____

Patient Phone #: _____ Email: _____

GASTROENTEROLOGIST:

- ☐ Prof Thomas Borody
- ☐ Dr Simon Benstock
- ☐ Dr Jeffrey Tu
- ☐ Prof Shan Rajendra
- ☐ Dr Antony Wettstein
- ☐ Dr Justine Mill
- ☐ Dr Arti Rattan
- ☐ Dr Gaurav Agrawal

COLORECTAL SURGEON:

- ☐ A/Prof Matt Rickard

IMMUNOLOGIST:

- ☐ Prof Robert Clancy

REQUEST FOR:

- ☐ Consultation
- ☐ Gastroscopy
- ☐ Colonoscopy
- ☐ Antibiotic Infusion Booking
- ☐ FMT Suitability
- ☐ Treatment of Haemorrhoids
- ☐ Urea Breath Test for H Pylori
- ☐ Small Bowel Capsule (SBC)
- ☐ Other _____

REASON FOR REFERRAL:

1. Date last colonoscopy if within last 5 years _____ Done at _____ .
2. Endoscopic report / Pathology of last colonoscopy if NOT performed at CDD.
3. Reason for referral

- ☐ PR Bleeding
- ☐ IBD- UC or CD
- ☐ Adenoma Surveillance
- ☐ Iron deficiency
- ☐ Change of bowel habit
- ☐ Upper GI symptoms
- ☐ CRC (Colorectal Cancer)
- ☐ Parasite Infection
- ☐ +ve FOBT
- ☐ Surveillance for family history CRC
- ☐ Other symptoms

Referring Doctor: _____

Address: _____

Signature: _____

Provider number: _____

Contact number: _____

Referring Practitioner's Stamp: