St Albans Endoscopy
PROFESSIONAL • QUALITY • CARE

BOOKINGS
Phone: **03 9364 0033** Fax: **03 9367 7432**
328-330 Station Road, St Albans, Vic, 3021

REFERRAL FORM

PATIENT DETAILS

Name:

Date of Birth:

Contact Number:

REFERRING DOCTOR DETAILS

Name:

Address:

Phone/Fax:

Provider No:

CLINICAL DETAILS

Date of Referral: / /

☐ **URGENT**

- ☐ **Consultation**
- ☐ **Colonoscopy**
- ☐ **Gastroscopy**
- ☐ **Colonoscopy/Gastroscopy**
- ☐ **Capsule Endoscopy**

YOUR APPOINTMENT

Date: / /

Time:

Referring Doctor's Stamp

FOR PATIENTS BEING REFERRED FOR A PROCEDURE - Please read the procedure instructions on the reverse page. You will be admitted for approximately 2-3 hours.

DOCUMENT NO: 1 V7 DATE OF ISSUE: JANUARY 2015