REFERRAL FORM

Coburg ENDOSCOPY Centre

Coburg Endoscopy Centre
15 Munro St
Coburg VIC 3058
Phone: 9044 4200
Fax: 9044 4222
Email: admin@coburgendo.com.au

Dear Dr Coburg Endoscopy,

I would like to refer the following patient

Patient Name: _____

Phone Number: _____

DOB: _____

FOR URGENT REFERRALS PLEASE TICK BOX ☐

Please provide a referral summary below

For consideration of:
(please select)

- ◯ Full Consultation

Or

- ◯ Open Access Pillcam
- ◯ Open Access Gastroscopy
- ◯ Open Access Colonoscopy
- ◯ Open Access Iron Infusion
- ◯ Helicobacter pylori Breath testing
- ◯ Oesophageal Impedance-pH study
- ◯ Open Access Fibroscan / Shearwave
- ◯ Hydrogen & Methane Breath Testing
  *Lactulose is a baseline test

Hb: _____ Ferrtin: _____ Date of result: _____

⊗ LACTULOSE ◯ LACTOSE ◯ FRUCTOSE ◯ SUCROSE ◯ SORBITOL ◯ INULIN ◯ GLUCOSE

Referring Doctor : _____ Date : _____

Provider Number : _____

Phone Number : _____ Sign : _____

Address : _____