Beacon Hospital

ENDOSCOPY DIRECT ACCESS REFERRAL FORM

TEL: 01 2938684. FAX: 01 2938641. EMAIL: COLPOSCOPY@BEACONHOSPITAL.IE

PATIENT DETAILS

Patient's Name | D.O.B.

Address | Home Telephone

Mobile

GP DETAILS

Name of Referring Doctor | Surgery Telephone

Surgery Address | Fax

Email

PRIORITY

URGENT ☐ Soon ☐ Routine ☐

MEDICAL INSURANCE

Company | Plan | Policy no.

ESSENTIAL QUSTIONS

Is the patient on any of the following: Warfarin ☐ Aspirin ☐ Plavix ☐

Indication for treatment:

If on Warfarin, have INR done prior to procedure.

Is the patient Diabetic? ☐ Yes ☐ No

If 'Yes' please tick as appropriate ☐ Type 1 ☐ Type 2

Procedure Required: ☐ OGD ☐ COLONOSCOPY

GASTROSCOPY INDICATION

Dyspepsia ☐ | Heartburn /Reflux ☐ | Dysphagia ☐ | Haematemesis ☐ | Nausea/ Vomiting ☐

Anaemia ☐ | Weightloss ☐ | Barretts Oesophagus ☐ | Varices Assessment ☐ | Epigastric Pain ☐

COLONOSCOPY INDICATION

PR Bleeding ☐ | Altered Bowel Habit ☐ | Iron Deficiency Anaemia ☐ | IBD Surveilance ☐

Family History of Colon Cancer ☐ | Previous Polyps ☐ | Abdominal Pain ☐

Other Indications

Duration of Symptoms

Past Medical History

Current Medications

Please advise patients to take their Blood Pressure medication with a sip of water on morning of procedure
For Colonoscopy, Please give patient a prescription for Klean Prep

Please Fax to: 01 293 8619 Enquires: 01 293 8652/8650 Endoscopy: 01 293 5694