Beacon Hospital

ENDOSCOPY DIRECT ACCESS REFERRAL FORM

TEL: 01 293 8656. FAX: 01 293 7552. EMAIL: ENDOSCOPYAPPOINTMENTS@BEACONHOSPITAL.IE

PATIENT DETAILS

Patient 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 QUESTIONS

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

Aspirin ☐ NOAC ☐ Please sepcify _____

Indication for treatment:

If on Warfarin, have INR done prior to procedure.

Is the patient on iron supplements? Yes ☐ No ☐ If 'Yes', name of supplement(s):

Is the patient Diabetic? ☐ Yes ☐ No

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

Procedure Required: ☐ OGD (code 194) ☐ COLONOSCOPY (code 455) ☐ FLEXIBLE SIGMOIDOSCOPY (code 450)

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 Moviprep