FOBT Colonoscopy Referral Form

Please Fax to 02 4943 5903

Date of Referral:	**Referring doctor details**
Referral to: Dr Stephen Philcox ☐ Dr Robert Gibson ☐ Dr Lay Gan ☐ Dr Thomas Goodsall ☐	Name : Contact # :

Patient details
Name : DOB : Address : Suburb : State : Contact # : Medicare # :

Medical History Requiring Specialist Consultation		**Medications Requiring Special Instructions**	
AMI/CABG/Stent	☐	Aspirin	☐
CCF	☐	Clopidogrel or similar	☐
AF	☐	Warfarin	☐
CVA/TIA	☐	Dabigatran or rivaroxaban	☐
COPD	☐	NSAIDs	☐
OSA	☐		☐
DM I/DM II (Please circle)	☐		☐
Insulin requiring	☐		
Oral hypoglycaemics	☐		

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