

Capsule Study Referral Form

Date of referral:**Referral to:**

- Dr Stephen Philcox
- Dr Robert Gibson
- Dr Lay Gan
- Dr Thomas Goodsall
- Dr Magnus Halland
- Dr Dane Cook

Referring Doctor details:

Name:

Practice:

Contact details:

Patient details

Name:

DOB:

Address:

Suburb:

State:

Contact:

Medicare:

Considerations:

- Known delayed motility issues
- previous upper GI surgery?

- Medication allergies? (please list below)
- Any history of dysphagia?

Other comments:

**Medical History Requiring
Specialist Consultation:**

- AMI/CABG/Stent
- CCF
- AF
- CVA/TIA
- COPD
- OSA
- DMI/DMII (please circle)
 - Insulin requiring?
 - Oral hypoglycaemics?

**Please fax to Hunter Gastroenterology
02 49435903**