Metro South Health

Direct Access Endoscopy (DAE) Referral Form

(Affix identification label here)

URN:

Family name:

Given name(s):

Address:

Date of birth: Sex: ☐ M ☐ F

To Be Completed By Facility

DO NOT WRITE IN THIS BINDING MARGIN

Patients are eligible for Direct Access Endoscopy (DAE) if the clinical assessment on the referral provided by the referring GP is compliant with the established criteria and the patient's comorbidities do not require further assessment by a specialist prior to the procedure. Referrals to DAE can be for suspected malignancy, positive FOBT, follow-up or surveillance procedures (<3 months from due date), strong familial history of gastrointestinal cancers or confirmation of coeliac disease with positive serology (or strong suspicion despite negative serology). Please ensure that **all** questions are answered and N/A (not applicable) is indicated where appropriate. Please also **provide a copy** and **explain** details of the consent information to your patient.

Referring to:

Beaudesert Logan
PAH QEII
Redland

Requested Procedure:

Gastroscopy

Colonoscopy

Name of Specialist (if applicable):

Indication (why does the patient require the procedure, e.g. confirmation of coeliac disease, suspicion of gastrointestinal cancers, surveillance, etc.):

DAE Criteria:

- **Age < 75 years (please provide ECG for patients over 50)**
- **BMI < 35**
- **No anaesthetic risks**
- **No major comorbidity (ASA1 & ASA2 only)**
- **No alcohol or drug dependancy**
- **Not on anticoagulant or antiplatelet therapy**

Age: **BMI:**

Height: **Weight:**

Relavant Comorbidities:

Cardiovascular yes no
Details:

Respiratory yes no
Details:

Renal yes no
Details:

Diabetes yes no
Details:

Increased Risk from Anaesthesia yes no
Details:

History of Surgical Complications yes no
Details:

Strong family history of gastrointestinal cancer yes no
Details:

Have you explained and provided consent info?
yes no

Patient Details

Family Name:

Given Name(s):

Date of Birth: Gender:

Address:

Phone (Home): Mobile:

Is an interpreter required?
no
yes Language**:**

PR bleed, visible blood on stool yes no
(attach recent FBC and iron study)

Iron deficiency/anaemia yes no
Post menopausal, not menorrhagia or dietary causes
(attach recent FBC and iron study)

Positive FOBT yes no
Attach report and identify pathology provider (SNP/Mater/QML/etc.):
Source:

Abdominal pain/discomfort
Location in abdomen (quadrant/central/etc.): yes no

Abnormal GIT Imaging yes no
(attach report)

Suspected coeliac disease yes no
(attach coeliac screen)

Chronic/relapsing vomiting or nausea yes no

Dysphagia/relevant swallowing disorder yes no

DAE Referral Form

Queensland Government

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Has the patient had a previous colonoscopy and/or gastroscopy? (If yes, please attach previous endoscopy and histopathology reports if conducted at an external facility)

no
yes

Procedure: Date:

Specialist: Facility:

Is the referral for surveillance of a known condition or from a previous pathology?

no
yes Reason:

Is the referral for a patient experiencing any other gastrointestinal symptoms? (If yes, please describe symptoms, conduct and attach ELFT, FBC, CRP and ESR in addition to any required investigations indicated on the first page)

Relevant past medical history and any additional clinical information to assist with determining urgency of procedure: Please include details about risk factors (family history of gastro-intestinal malignancy, personal history of excessive alcohol consumption or smoking), relevant personal past medical history (e.g. Barrett's oesophagus, inflammatory bowel disease, DVT in last year, previous malignancy)

Allergies:

Is the patient's medication list attached?

no Reason(e.g. patient is not on any regular medication):
yes

Referring Doctor Details:

Name: Practice:
Address:
Phone: Fax:
Provider No: Date: Signature:

Please check that ALL sections on this form have been completed before submitting.

Fax completed form to: Central Referral Hub
Fax: 1300 364 248

For more information, please refer to:
www.metrosouth.health.qld.gov.au/dae
Or phone the Metro South Central Referral Hub at 1300 364 155 for any enquiries regarding referrals

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