NORTHERN HEALTH

Northern Health

ENDOSCOPY CAPSULE ENDOSCOPY REFERRAL

AFFIX PATIENT IDENTIFICATION LABEL HERE

U.R. NUMBER: ______________________

SURNAME: ______________________

GIVEN NAME: ______________________

DATE OF BIRTH: ____/____/____ SEX: ________

❑ 3 points of ID checked

Indication (s)		
❑ Obscure overt GI bleeding	❑ Iron deficiency anaemia	❑ Peutz-Jegher's Syndrome
Details:		

Recent / previous investigations (* denotes mandatory field)

Haemoglobin (g/L)*	Most recent:			Date: ____/____/____
	Lowest past 1 year:			Date: ____/____/____
Gastroscopy*	Date: ____/____/____			Result
	Date: ____/____/____			Result
Colonoscopy*	Date: ____/____/____			Result
	Date: ____/____/____			Result
Push enteroscopy	❑ Yes	❑ No	Date: ____/____/____	Result
			Date: ____/____/____	Result
Imaging (CT / MRI) (Please specify type)	❑ Yes	❑ No	Date: ____/____/____	Result
			Date: ____/____/____	Result
Previous capsule endoscopy*	❑ Yes	❑ No	Date: ____/____/____	Result
Other relevant investigations	Date: ____/____/____			Result

Relevant medical history

History of aspirin / NSAID use	❑ Yes	❑ No
History of other anti-platelets / anticoagulants	❑ Yes	❑ No
History of obstructive bowel symptoms or Crohn's disease	❑ Yes[1]	❑ No
History of dysphagia or gastroparesis	❑ Yes[2]	❑ No
Pacemaker / ICD	❑ Yes	❑ No
Pregnant	❑ Yes	❑ No
Diabetes mellitus *requiring insulin*	❑ Yes	❑ No

[1] May need patency capsule prior

[2] May need gastroscopy with capsule introducer

Referred by Dr: ______________________ (Please Print) Signature: ______________ Provider No: ______________

Referring Unit: ______________________ Date: ____/____/____ Contact No: ______________

Appointment time frame: ❑ Urgent (possible active bleeding) ❑ Inpatient ❑ Outpatient

Please note: In order to schedule an appointment, a valid referral including consent is required. All fields above need to be completed. Invalid referrals will be returned to the referring unit.

NOTE: REFERRING DOCTOR OR UNIT MAY BE LIABLE FOR CAPSULE COSTS IF THE MBS CRITERIA LISTED ABOVE NOT MET. FUNDING BY REFERRING UNIT WILL NEED APPROVAL BY HEAD OF REFERRING UNIT

Office Use Only

Date referral received: ____/____/____ Received by: (print name) ______________________

Please email form to NH-GIInvestigations@nh.org.au. Oncology and Medical Day Unit Phone: 8468 8664

ENDOSCOPY – CAPSULE ENDOSCOPY REFERRAL

330350

Northern Health **ENDOSCOPY** **CAPSULE ENDOSCOPY** **REFERRAL**	AFFIX PATIENT IDENTIFICATION LABEL HERE U.R. NUMBER: ____________ SURNAME: ____________ GIVEN NAME: ____________ DATE OF BIRTH: ____/____/____ SEX:________

Capsule Endoscopy Patient / Medical Treatment Decision Maker Consent

Capsule endoscopy is considered a very safe procedure. Possible risks include:

Common:

Incomplete procedure because capsule does not reach large bowel during the capsule recording (about 1 in 10 people).

Uncommon:

Difficulty in swallowing capsule (about 1 in 100 people)

Capsule retention, or inability of capsule to pass through small bowel (about 1 in 100 people). Usually the capsule passes through eventually, but this may rarely require endoscopy or surgery for removal.

Rare:

Severe abdominal pain

Patient / Medical Treatment Decision Maker consent to capsule endoscopy

I have been explained and understand the capsule endoscopy for myself/on behalf of the patient named below. The clinician has explained the procedure and its risks to me, and the likely outcomes if these complications occur. The clinician has also explained relevant treatment options as well as the risks of not having the procedure. I understand that a doctor other than the clinician requesting this procedure may perform the procedure. I understand that images and data obtained from my capsule endoscopy may be used, in a de-identified manner, for educational purposes. I consent to the administration of the capsule endoscopy.

Print name: ____________________ Signature: ____________________

Relationship to patient (if patient not signing for self) ____________________ Date:____________

Clinician declaration or provision of information regarding capsule endoscopy

I, Dr ____________________, have explained the capsule endoscopy to the patient and/or medical treatment decision maker, including its benefits, risks and alternatives.

Signature of clinician ____________________ Date ____________

Interpreter Service Present: ❑ Yes ❑ No ❑ N/A Language Required: ____________________

Declaration by the Interpreter:

I have given a translation in ____________________ (state the Patient's/Medical Treatment Decision Maker's language) of any verbal and written information given to the Patient/Medical Treatment Decision Maker by the doctor.

Interpreter Name: ____________________ Interpreter Signature: ____________________