## Northern Health

AFFIX PA	TIENT IDE	NTIFICA	TION LABEL HERI	=
J.R. NUMBER:				
SURNAME:				
GIVEN NAME:			1	-
DATE OF BIRTH	1	1	SEX.	

SURNAME:   GIVEN NAME:   GIV						
REFERRAL   DATE OF BIRTH:	2.1.2.0.000.					
DATE OF BIRTH:/ SEX:			GIVEN NAME:			<u> </u>
Indication (s)	KLILKI	VAL.	DATE OF BIRTH:	//SEX	:	
Indication (s)					3 points of	D checked
Details:    Paemoglobin (g/L)*   Most recent:	Indication (s)					
Details:    Details:	☐ Obscure overt GI	oleeding 🔲	☐ Iron deficiency anaemia	☐ Peutz-Jegher's Sv	ndrome	
Haemoglobin (g/L)*   Most recent:   Date:/     Lowest past 1 year:   Date:/     Gastroscopy*   Date:/   Result     Colonoscopy*   Date:/   Result     Date:/   Result     Date:/   Result     Date:/   Result     Date:/   Result     Date:/   Result     Push enteroscopy   Date:/   Result     Push enteroscopy   Date:/   Result     Previous capsule					-	
Haemoglobin (g/L)*   Most recent:   Date:/     Lowest past 1 year:   Date:/_     Date:/_   Result     Date:/   Result     Date:/_   Result     Previous capsule endoscopy*   Yes   No   Date:/_   Result     Previous capsule endoscopy*   Date:/_   Result     Previous capsule endoscopy*   Yes   No   Date:/_   Result     Previous capsule endoscopy*   Yes   No   Date:/_   Result     Previous capsule endoscopy*   Yes   No   No     Date:/_   Result     Previous capsule endoscopy*   Yes   No   No     Date:/_   Result     Previous capsule endoscopy*   Yes   No   No     History of aspirin / NSAID use   Yes   No   No     History of other anti-platelets / anticoagulants   Yes   No   No     History of obstructive bowel symptoms or Crohn's disease   Yes   No   No     Pregnant   Yes   No   No     Diabetes mellitus requiring insulin   Yes   No     Diabetes mellitus requiring insulin   Yes   No     No   No   No   No   No   No						
Lowest past 1 year:	Recent / previous inve	stigations (*	* denotes mandatory field)			
Lowest past 1 year:	Haemoglobin (g/L)*	Most recent:	t:	Date://_		
Gastroscopy*  Date:/ Result  Date:/ Result  Date:/ Result  Date:/ Result  Date:/ Result  Push enteroscopy  Push enteroscopy  Push enteroscopy  Date:/ Result  Previous capsule endoscopy*  Other relevant investigations  Result Result  Result  Previous capsule of Yes Other No Date:/ Result  Date:/ Result  Date:/ Result  Date:/ Result  Date:/ Result  Previous capsule of Yes Other Result  Previous capsule of Yes Other Result  Date:/ Result  Da	- ,,,	Lowest past	st 1 year:			
Colonoscopy*  Date:/ Result  Date:/ Result  Push enteroscopy	Gastrosconu*	Date:				
Date:       Result   Result   Result   Date:     Result   Result	Gasiroscopy					
Push enteroscopy    Yes	Colonoscopy*	Date:	<u> </u>	50.540.000.200.6440		
Push enteroscopy    Yes	Обютовсору	Date:	<del>-''</del>	Result		
Date:/   Result	Push enteroscopy	□ Yes □ No	0			
Imaging (CT / MRI) (Please specify type)	1 don ontorocopy	_ 100 <b>_</b> 110	Date://			
Previous capsule endoscopy*			Date://	Result		
endoscopy*  Other relevant investigations  Relevant medical history  History of aspirin / NSAID use  History of other anti-platelets / anticoagulants  History of obstructive bowel symptoms or Crohn's disease  History of dysphagia or gastroparesis  Pacemaker / ICD  Pregnant  Diabetes mellitus requiring insulin  May need patency capsule prior		□ Yes □ No	Date://	Result		. *
Other relevant investigations  Relevant medical history  History of aspirin / NSAID use History of other anti-platelets / anticoagulants  History of obstructive bowel symptoms or Crohn's disease History of dysphagia or gastroparesis  Pacemaker / ICD Pregnant Diabetes mellitus requiring insulin  May need patency capsule prior	L. D. Werner, Andrewson Strategy Control Manager	□ Yes □ No	Date://	Result		
Investigations  Relevant medical history  History of aspirin / NSAID use  History of other anti-platelets / anticoagulants  History of obstructive bowel symptoms or Crohn's disease  History of dysphagia or gastroparesis  Pacemaker / ICD  Pregnant  Diabetes mellitus requiring insulin  May need patency capsule prior						
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History of aspirin / NSAID use  History of other anti-platelets / anticoagulants  History of obstructive bowel symptoms or Crohn's disease  History of dysphagia or gastroparesis  Pacemaker / ICD  Pregnant  Diabetes mellitus requiring insulin  May need patency capsule prior	Relevant medical hist	orv				
History of other anti-platelets / anticoagulants  History of obstructive bowel symptoms or Crohn's disease  History of dysphagia or gastroparesis  Pacemaker / ICD  Pregnant  Pregnant  Wes  No  Pregnant  Pregnant  Wes  No  No  No  No  Pacemaker of the platelets / anticoagulants  Wes  No  No  No  Pregnant  Wes  No  No  No  No  No  No  No  No  No  N					☐ Yes	☐ No
History of dysphagia or gastroparesis  Pacemaker / ICD  Pregnant  Diabetes mellitus requiring insulin  May need patency capsule prior	History of other anti-pl	atelets / antico	coagulants		☐ Yes	□ No
Pacemaker / ICD	,					□ No
Pregnant						
Diabetes mellitus requiring insulin  1 May need patency capsule prior						☐ No
<sup>1</sup> May need patency capsule prior	Pregnant					
	Diabetes mellitus requ	iring insulin			☐ Yes	□ No
			roducer			^
Referred by Dr: Signature: Provider No:	Referred by Dr:		Signature:	Provider No		
		ā ā	The same of the sa			
Referring Unit: Date:// Contact No:	Referring Unit:		/ Date:/_	Contact No:		
Appointment time frame: ☐ Urgent (possible active bleeding) ☐ Inpatient ☐ Outpatient	Appointment time frame	: 🗆 Urge	gent (possible active bleeding)	) ☐ Inpatient	□ Outpatie	nt
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.				(No1)	is required	. All fields
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)		. 1	/ Received by: (prin	nt name)		
Please email form to NH-GIInvestigations@nh.org.au. Oncology and Medical Day Unit Phone: 8468 8664					2000: 9460 f	

Prompt Doc No: NHS0075527 v14.3 DO NOT DOCUMENT IN THIS MARGIN Last Updated: 10/06/2022 Due for Review: 10/06/2025 Page 1 of 2



## Northern Health

## ENDOSCOPY CAPSULE ENDOSCOPY REFERRAL

AFFIX PATIENT IDENTIFICATION LABEL HERE				
U.R. NUMBER:				
SURNAME:				
GIVEN NAME:				

	REFERRAL	DATE OF BIRTH:/SEX:						
	Capsule Endoscopy Patie	nt / Medical Treatment Decision Maker Consent						
Ca	Capsule endoscopy is considered a very safe procedure. Possible risks include:							
Co	ommon:							
Inc	complete procedure because capsule do	pes not reach large bowel during the capsule recording (about 1 in 10						
ре	people).							
Ur	Uncommon:							
Dif	Difficulty in swallowing capsule (about 1 in 100 people)							
Ca	psule retention, or inability of capsule to	pass through small bowel (about 1 in 100 people). Usually the capsule						
pa	sses through eventually, but this may rar	rely require endoscopy or surgery for removal.						
Ra	re:							
Se	vere abdominal pain							
Pa	tient / Medical Treatment Decision Maker	consent to capsule endoscopy						
١								
	I have been explained and understand the capsule endoscopy for myself/on behalf of the patient named below.							
1	50 51	and its risks to me, and the likely outcomes if these complications occur.						
1	70 10 10 10 10 10 10 10 10 10 10 10 10 10	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							
pu	rposes. I consent to the administration of	f the capsule endoscopy.						
_	to be a second	Cinnatura						
Pr	int name:	Signature:						
R	elationship to patient (if patient not signing f	for self) Date:						
110	stationship to patient (ii patient not signing i	Date						
CI	inician declaration or provision of info	ormation regarding capsule endoscopy						
	•							
1, [	Or	, have explained the capsule endoscopy to the patient and/or						
	edical treatment decision maker, including							
Si	gnature of clinician	Date						
Let	Interpreter Service Present: ☐ Yes ☐ No ☐ N/A Language Required:							
1111	erpreter Service Present. d res dino	Language Required.						
	eclaration by the Interpreter:							
		(state the Patient's/Medical Treatment						
De	ecision Maker's language) of any verbal a	and written information given to the Patient/Medical Treatment						
De	Decision Maker by the doctor.							
Int	erpreter Name:	Interpreter Signature:						

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