FNH330361

Northern Health

# GI ULTRASOUND CLINC REFERRAL

AFFIX PATIENT IDENTIFICATION LABEL HERE

U.R. NUMBER: _____

SURNAME: _____

GIVEN NAME: _____

DATE OF BIRTH: _____/_____/_____ SEX: _____

**Enquiries:** GI Investigations Telephone: 8468 8664
**Send referral to:** NH-GIInvestigations@nh.org.au
**Address:** Oncology and Medical Day Unit, Main Ward Block, Northern Hospital, 185 Cooper St Epping Vic 3076

| **Patient Details** | | | | | | *mandatory fields |
|---|---|---|---|---|---|---|
| Family Name* | | | Given Name* | | | |
| Date of Birth* | _____/_____/_____ | | Sex ☐ Female ☐ Male ☐ Other | | | |
| Address* | | | | Telephone* | | |
| Medicare No. | | | Reference No. | | Expiry | |
| Interpreter | ☐ Yes ☐ No | Language | | | | |

**Reason for referral / health issues to be addressed:**

☐ **Suspected disorder of gut-brain interaction**
☐ **Suspected inflammatory bowel disease**
☐ **Confirmed inflammatory bowel disease**

**Inflammatory Bowel Disease Classification (if applicable)**

| **Crohn's Disease** | | **Ulcerative Colitis** |
|---|---|---|
| ☐ **L1**: Ileal | ☐ **L4**: Jejunal | ☐ **C1**: Proctitis |
| ☐ **L2**: Right colon | ☐ **L3**: Ileal + right colon | ☐ **C2**: Left sided colitis (to splenic flexure) |
| ☐ **L2**: Left colon | ☐ **L3**: Ileal + left colon | ☐ **C3**: Extensive colitis |
| ☐ **L2**: Pan colitis | ☐ **L3**: Ileal + pancolitis | |
| ☐ **L4**: Upper GI | ☐ **P1**: Perianal fistulae | |

| **Current IBD Medications (if applicable)** | | **Previous Surgery (if applicable)** |
|---|---|---|
| ☐ Prednisolone | ☐ 6MP | ☐ Nil |
| ☐ Budesonide | ☐ Methotrexate | ☐ Isolated small bowel resection |
| ☐ Hydrocortisone | ☐ Infliximab | ☐ Ileocaecal resection |
| ☐ Sulfasalazine | ☐ Adalimumab | ☐ Right Hemicolectomy |
| ☐ Mesalazine | ☐ Vedolizumab | ☐ Left Hemicolectomy |
| ☐ Azathioprine | ☐ Ustekinumab | ☐ Subtotal colectomy |
| ☐ Tofacitinib | ☐ Upadacitinib | ☐ Other |
| ☐ Calcineurin Inhibitors (ciclosporin / tacrolimus) | ☐ Ozanimod<br>☐ Other | |

| **Priority** | ☐ Urgent (< 30 days) ☐ Specify time frame | | |
|---|---|---|---|
| **Referrer Details** | Date of Referral | _____/_____/_____ | Provider No |

| Name | | Address | |
|---|---|---|---|
| Telephone | | Email | |
| Fax | | Copies to | |
| Office use only | Date referral received: _____/_____/_____ | Received by: | Print name: |

HEALTH NORTHERN

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