

Rapid Access Faecal Occult Blood Test Clinic Referral

Patients Information or Sticker Label			
MRN	Surname*	First Name*	Interpreter if required Language: _____
Gender* <input type="checkbox"/> Male <input type="checkbox"/> Female	DOB*	Contact Number*:	
Address*:			
Relevant Information			
Does this patient have FOBT positive result?* <input type="checkbox"/> Yes <input type="checkbox"/> No			
Source: From NBCSP <input type="checkbox"/> Date received result: _____ From Self-test kit(e.g. Rotary Bowel scan) <input type="checkbox"/> Date received result: _____ Reason for self-test: _____ Other: _____ Date received result: _____			
Does the patient have overt rectal bleeding? <input type="checkbox"/> Yes <input type="checkbox"/> No			
High risk features?			
Weight loss		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Abdominal mass		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Iron deficiency anaemia		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Palpable or visible rectal mass		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Chronic kidney disease EGFR < 60 ml/min/1.73m2		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cirrhosis or advanced liver disease		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Chronic respiratory disease		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Obstructive sleep apnoea		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Smoker ? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Allergies <input type="checkbox"/> Nil Allergy: _____			
Family history	First degree relative with Colorectal Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No Please select Family member and indicate age at the diagnosis <input type="checkbox"/> Father ____ <input type="checkbox"/> Mother ____ <input type="checkbox"/> Brother ____ <input type="checkbox"/> Sister ____ <input type="checkbox"/> Children ____ <input type="checkbox"/> Other		
Relevant Blood tests	Please attach any recent blood test results, especially: <i>Full Blood count, Iron studies</i>		
Other investigations	Please specify:		
Previous Colonoscopy?	<input type="checkbox"/> Yes Date : _____ <input type="checkbox"/> No If Yes, Please attach results of previous colonoscopies:		
MANDATORY INFORMATION			
Past medical history attached?* <input type="checkbox"/> Yes (MANDATORY) Past medical history and list of current List of current medications attached?* <input type="checkbox"/> Yes (MANDATORY) medications MUST BE ATTACHED Recent blood test (FBC, UEC, LFT, Creatinin, Iron studies) and FOBT RESULTS Referral will not be processed until past medical history and current medication is received.			
REFERRING DOCTOR DETAILS			
Referring Doctor – Practice stamp or details*		Doctor's Provider Number:*	
		Date:*	