Health
Northern Sydney
Local Health District

Rapid Access Faecal Occult Blood Test Clinic Referral

Patients Information or Sticker Label			
MRN	**Surname***	**First Name***	**Interpreter if required** **Language:_____**
Gender* ☐ **Male** ☐ **Female**		**DOB***	**Contact Number*:**
Address*:			

Relevant Information

Does this patient have FOBT positive result?* ☐ **Yes** ☐ **No**

Source: **From NBCSP** ☐ **Date received result:_____**
From Self-test kit(e.g. Rotary Bowel scan) ☐ **Date received result:_____**
Reason for self-test:_____
Other:_____ Date received result:_____

Does the patient have overt rectal bleeding?		☐ **Yes**	☐ **No**
Hight risk features?	**Weight loss**	☐ **Yes**	☐ **No**
	Abdominal mass	☐ **Yes**	☐ **No**
	Iron deficiency anaemia	☐ **Yes**	☐ **No**
	Palpable or visible rectal mass	☐ **Yes**	☐ **No**
	Chronic kidney disease EGFR < 60 ml/min/1.73m2	☐ **Yes**	☐ **No**
	Cirrhosis or advanced liver disease	☐ **Yes**	☐ **No**
	Chronic respiratory disease	☐ **Yes**	☐ **No**
	Obstructive sleep apnoea	☐ **Yes**	☐ **No**

Smoker ? ☐ **Yes** ☐ **No**

Allergies ☐ **Nil** **Allergy: _____**

Family history	**First degree relative with Colorectal Cancer** ☐ **Yes** ☐ **No** **Please select Family member and indicate age at the diagnosis** ☐ **Father ____** ☐ **Mother____** ☐ **Brother ____** ☐ **Sister ____** ☐ **Children ____** ☐ **Other**
Relevant Blood tests	**Please attach any recent blood test results, especially:** ***Full Blood count, Iron studies***
Other investigations	**Please specify:**
Previous Colonoscopy?	☐ **Yes Date :_____** ☐ **No** **If Yes, Please attach results of previous colonoscopies:**

MANDATORY INFORMATION

Past medical history attached?* ☐ **Yes (MANDATORY)** **Past medical history and list of current List of current medications attached?*** ☐ **Yes (MANDATORY)** **medications MUST BE ATTACHED Recent blood test (FBC, UEC, LFT, Creatinine, 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:*

Please click on the appropriate links (relevant to catchment area) below to submit the form:
For Ryde hospital FOBT Clinic: Email: NSLHD-RYDE-DAC@health.nsw.gov.au or fax 9845 7011
Ph: 98587174 Mobile: 0474 013 823