A/Prof. John Lubel
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Kew Gastroenterology
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Medicare card number

PRIVATE SPECIALIST REFERRAL

Surname, Given Name (including middle initials) | Sex | Date of birth | Your reference

Address | Phone (home) | Phone (business)

Endoscopy Required* (tick as required):

- ☐ Gastroscopy
- ☐ Colonoscopy
- ☐ Sigmoidoscopy
- ☐ Push Enteroscopy

Consultation Request:

- ☐ Urgent consultation
- ☐ Routine consultation

* In most circumstances a consultation prior to endoscopy with the specialist is advisable in order to: i) check medications (such as diabetic and anticoagulant medications), ii) plan which biopsies are required and, iii) to counsel patients on the risk versus benefit of bowel preparation and endoscopy. In some cases, endoscopy will not be warranted and this will need to be discussed with the patient.

Clinical Notes - including indication for endoscopy (see below) and relevant medications.

Patients with clinically significant medical comorbidities (e.g. obesity, diabetes, hypertension and other cardiac history and/or anticoagulants) may require consultation prior to procedure.

Private: ☒

REQUESTING DOCTOR SIGNATURE AND REQUEST DATE:

☒ DOCTOR DATE

Copy Reports To:

Hospital/Ward

Referring Doctor (Name, Address, Provider No.)

Referral to:
A/Prof John Lubel
Kew Gastroenterology
203 Barkers Road
Kew, Melbourne
Victoria 3101

☐ **A. Low risk ➾ Colonoscopy at 10 years or NBCSP FOBT**
1-2 adenoma **and** All < 10mm, no villous features, no high-grade features

☐ **B. Moderate risk➾ Colonoscopy at 5 years**
3-4 tubular adenomas <10 mm, ≤2 Sessile serrated polyps < 10 mm

☐ **C. High risk➾ Colonoscopy at 3 years**
5-9 adenomas < 10mm, Adenoma ≥10mm or high-grade dysplasia villous, 3-4 sessile serrated <10mm or 1-2 > 10mm or dysplasia Hyperplastic poly ≥10mm

☐ **D. Multiple adenomas ➾ Colonoscopy at 1 year**
≥ 10 < 10mm, 5-9 adenomas ≥10mm or HGD. ≥5 SSP < 10mm

☐ **E. Incomplete excision ➾ Colonoscopy at 3-6 months**

☐ **1. Active disease/high risk ➾ Colonoscopy at 1 year**
active disease, PSC, stricture, multiple inflammatory polyps, shortened colon, previous dysplasia

☐ **2. Inactive/moderate risk➾ Colonoscopy at 3 years**
Inactive UC with no high-risk features **or** Crohn's disease with no high-risk features, and No FDR with CRC at age < 50 years

☐ **3. If group for 2 scopes ➾ Colonoscopy at 5 year**
If 2 consecutive scopes in group 2 report normal endoscopic and histological findings

☐ **1. Low risk ➾ Colonoscopy not recommended**
First **or** second-degree relative (SDR) diagnosed with colon cancer age ≥ 55 years (at time of diagnosis - relative risk x1-2)

☐ **2. moderate risk➾ Colonoscopy 5 yearly (from age 50 or 10 years younger than age of first diagnosis)**
1 FDR or SDR age ≤ 55 years at diagnosis **or** 2 FDR or 1 FDR and 1 SDR same side of family at any age of diagnosis.

☐ **3. Familial syndrome ➾ Colonoscopy every 1-2 years**
Refer to guidelines, genetics referral

INDICATIONS FOR COLONOSCOPY:

A. SYMPTOMS AND INVESTIGATIONS (critical factors)

- ☐ POSITIVE FOBT (NBCSP = ☐ OR NOT NBCSP = ☐)
- ☐ ANAEMIA: HB______, MCV______
- ☐ IRON DEFICIENCY: FERRITIN______
- ☐ RECTAL BLEEDING, DURATION______MONTHS
- ☐ AGE ≥ 60 YEARS
- ☐ CHANGE IN BOWEL HABIT FOR______MONTHS
- ☐ CONSTIPATION FOR______MONTHS
- ☐ DIARRHOEA FOR______MONTHS
- ☐ ABDOMINAL PAIN FOR______MONTHS
- ☐ WEIGHT LOSS
- ☐ PALPABLE MASS
- ☐ POSSIBLE INFLAMMATORY BOWEL DISEASE (IBD)
- ☐ PRIMARY OF UNKOWN ORIGIN
- ☐ ABNORMAL IMAGING

B. SURVEILLANCE

- ☐ ADENOMA SURVEILLANCE
- ☐ IBD SURVEILLANCE
- ☐ FAMILY HISTORY RISK FOR COLORECTAL CANCER
- ☐ COLORECTAL CANCER

C. THERAPEUTIC

- ☐ HAEMORRHOIDAL BANDING
- ☐ POLYP ≥ 2CM
- ☐ EMR
- ☐ STENTING
- ☐ DILATION ☐ PEG ☐ OTHER