Patient Referral

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CONSULTING Cabrini Malvern and Cabrini Brighton

REFERRER DETAILS

Referrer name _____ Practice name _____

Provider number (optional) _____ Phone _____ Email _____

PATIENT DETAILS

Patient name _____ Date of birth _____

Patient phone _____ Patient email (optional) _____ Medicare number (optional) _____

REASON FOR REFERRAL

- ☐ Colonoscopy
- ☐ Positive bowel screening test
- ☐ Rectal bleeding
- ☐ Bowel cancer concern
- ☐ Haemorrhoids
- ☐ Anal fissure
- ☐ Diverticular disease
- ☐ Rectal prolapse
- ☐ Faecal incontinence
- ☐ Pelvic floor disorder
- ☐ Inflammatory bowel disease
- ☐ Other

URGENCY

- ☐ Routine
- ☐ Semi-urgent
- ☐ Urgent

CLINICAL INFORMATION

Presenting symptoms, duration, relevant history, medications, investigations to date.

Please attach relevant pathology, imaging and prior endoscopy reports where available.

This referral is not for emergencies. If the patient requires urgent medical attention, please direct them to the nearest Emergency Department or Cabrini Emergency Department where appropriate.