Health
Western Sydney
Local Health District

# Rapid Access Faecal Occult Blood Test Clinic Referral

* Indicates Manditory Field

Clear Form

## Patient Information Or Sticker Label

| MRN | Surname* | First Name* | Interpreter if required<br>Language _____ |
|---|---|---|---|
| Gender* ☐ Male ☐ Female | | DOB* | Contact numbers:* |
| 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 Bowelscan) ☐ Date received result: _____

Reason for self-test: _____

Other: _____ Date received result: _____

| | | | |
|---|---|---|---|
| Does the patient have overt rectal bleeding? | | ☐ Yes | ☐ No |
| High risk features? | Weight loss | ☐ Yes | ☐ No |
| | Abdominal mass | ☐ Yes | ☐ No |
| | Iron deficiency anaemia | ☐ Yes | ☐ No |
| | Palpable or visible rectal mass | ☐ Yes | ☐ No |

Smoker? ☐ Yes ☐ No

Allergies ☐ Nil ☐ Allergy: _____

Family history

First degree relatives with Colorectal Cancer ☐ Yes ☐ No

Please select family member and indicate age at diagnosis

☐ Father ____ ☐ Mother ____ ☐ Brother ____ ☐ Sister ____

☐ Children ____ ☐ Other (specify)_____

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)**

List of current medications attached?* ☐ Yes **(MANDATORY)**

Past medical history and list of current medications **MUST BE ATTACHED.**

**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 Westmead FOBT Clinic: **Email:** WSLHD-Westmead-FOBT@health.nsw.gov.au or **fax: (02) 8890 5118** Enquiry: 0439 702 568

For Blacktown FOBT Clinic: **Email:** WSLHD-Blacktown-FOBT@health.nsw.gov.au or **fax: (02) 9881 8208** Enquiry: 0439 950 528

**Submit Form to Westmead FOBT** **Submit Form to Blacktown FOBT** **Save Form** **Print Form**