Health
Western Sydney
Local Health District

Facility:

RAPID ACCESS FAECAL OCCULT BLOOD TEST CLINIC REFERRAL

FAMILY NAME | MRN

GIVEN NAME | ☐ MALE ☐ FEMALE

D.O.B. _____ / _____ / _____ | M.O.

ADDRESS

LOCATION / WARD

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

Patient Information

Contact numbers:

Interpreter required: ☐ Yes ☐ No
Language:

Mandatory Information

Past medical history attached? **(MANDATORY)** ☐ Yes

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

Relevant Information:

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

Source: From NBCSP ☐ Date received result: _____

From Self-test Kit ☐ Date received result: _____

(e.g. Rotary Bowelscan)

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 ☐ or Allergy: _____
Family history	First degree relatives with Colorectal Cancer ☐ Yes ☐ No Age at 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.

Referring Doctor – Practice stamp or details

Doctor's Signature:

Date:

Please tick the appropriate FOBT clinic

☐ Westmead FOBT clinic: please email this form to WSLHD-Westmead-FOBT@health.nsw.gov.au or fax to: (02) 8890 5118
Please call 0439 702 568 if you have any questions

☐ Blacktown FOBT clinic: please email this form to WSLHD-Blacktown-FOBT@health.nsw.gov.au or fax to: (02) 9881 8208
Please call 0439 950 528 if you have any questions

BINDING MARGIN - NO WRITING

RAPID ACCESS FAECAL OCCULT BLOOD TEST CLINIC REFERRAL

WSHR-0254

030421

NO WRITING