Gastro Intestinal Ultrasound Service Referral Form

Department of Gastroenterology
St Vincent's Hospital Melbourne 35 Victoria Parade Fitzroy VIC 3065

Please **FAX** referral to **(03) 9231 3489**

Attention: PO Abdominal Ultrasound Clinic

Dr Emily Wright
Dr Emma Flanagan
Dr Julien Schulberg

Urgent Referral:	
☐Yes	☐No

Date:	

PATIENT INFORMATION (or affix sticker):					
Given Name:				**Surname:**	
DOB:		**URN:**		**Medicare No:**	
Address:					
Phone:				**Email:**	

REFERRING PHYSICIAN:					
Doctor Name:					
Hosp/Clinic:					
Address:					
Phone:		**Fax:**		**Email:**	
Provider No:				**Signature:**	

REASON FOR REFERRAL:		
☐ Investigation of GI Symptoms	☐ Assessment of known IBD (UC/CD)	☐ Incomplete colonoscopy

MEDICAL HISTORY:

SV999686

ADDITIONAL INFORMATION:			
Abnormal inflammatory markers (if known):	Date/Result:		
Faecal calprotectin (if known):	Date/Result:		
Pregnant?	☐ Yes	☐ No	If yes, weeks gestation:

For enquiries about appointments please call SVHM Specialist Clinics (03) 9231 3475

For clinical enquiries, please email: IBDnurse.vic@svha.org.au or phone: (03) 9231 3592

Thank you for your referral.