
drmathewkeegan.com

DR MATHEW KEEGAN
MBBS FRACP

# RAPID ACCESS REFERRAL

## Rapid Access Referral

Procedure requested *

- ○ Gastroscopy
- ○ Colonoscopy
- ○ Gastroscopy and colonoscopy
- ○ Endoscopic Ultrasound (EUS)
- ○ Balloon Enteroscopy

## Patient Details

First Name *

Middle Name(s) *

Last Name *

Date of Birth *

Gender

Occupation

Patient Address *

Street address *

Street address line 2

City *

State *

Please select

Postcode *

Patient Contact *

Patient Email

## Memberships

Does the patient have Medicare? *

○ Yes ○ No

Medicare Number

Ref #

Expiry Date

Does the patient have private health insurance? *

○ Yes ○ No

Private Health Fund Name

Member Number

Does the patient have a pension card? *

- ◯ Yes
- ◯ No

Pension Card Number

Is the patient a member of the Department of Veterans Affairs? *

- ◯ Yes
- ◯ No

Repatriation Number

## Referrer Information

Name *

Provider Number *

Clinic / Practice Address *

Street address *

Street address line 2

City *

State *

Please select

Postcode *

Contact Number *

Email Address *

HealthLink EDI

Date of Referral *

INDICATIONS: Gastroscopy *

- ◯ Reflux
- ◯ Barrett's surveillance
- ◯ Positive coeliac tests
- ◯ Gastric intestinal metaplasia surveillance
- ◯ Others (please specify below)
- ◯ N/A

INDICATIONS: Colonoscopy *

- ◯ FOBT Positive/NBCSP
- ◯ PR bleeding
- ◯ Family hx CRC
- ◯ Past polyps (New medicare item numbers require that the timeframe for surveillance is based on past colonoscopy findings and histology. If the patient or referring doctor could provide these, it would faciliate triage.)
- ◯ Others (please specify below)
- ◯ N/A

Reason(s) for Referral (and other indications not listed above)

Upload relevant documents (if any)

Browse

Medical History *

- [ ] Respiratory disease
- [ ] Obstructive sleep apnoea
- [ ] Heart condition
- [ ] Pulmonary hypertension
- [ ] Diabetes
- [ ] Renal impairment
- [ ] Liver disease
- [ ] Cancer
- [ ] Bleeding and/or clotting disorder
- [ ] Other

Details of Medical History

What scans have been performed? (if any)

Please specify Radiology practice / lab

Surgical History

Please provide history of surgery performed, surgeon, hospital, year/date.

## Patient Medications

Medications *

- [ ] Anti-coagulant
- [ ] Anti-arrhythmic agent
- [ ] Anti-platelet
- [ ] Oral diabetes medications (please flag SGLT2 inhibitors [-flozins])
- [ ] Insulin
- [ ] Ozempic / Wegovy / Mounjaro
- [ ] Allergies

Details of Medications

Other Relevant Information

## Additional Information

If you're a new referrer, how did you hear about Dr Keegan?

- [ ] Please confirm that you have read our Privacy Policy. *

Signature *

Date *