INTESTINAL ULTRASOUND REFERRAL

TheAlfred

Gastroenterology Department
Alfred Centre, Ground floor
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Ph: (03) 9076 2223 Fax: (03) 9076 2194

UR: _____

Surname: _____

Given Name: _____

Date of Birth: _____/_____/_____ Sex: M / F

Address: _____

_____ Postcode: _____

Phone (H): _____ Phone (W): _____

Phone (M): _____

Interpreter required: Y / N Language: _____

Date: _____

Referring Doctor: _____

Address: _____

_____ Postcode: _____

Provider No: _____

CC (if necessary) _____

_____

Signature: _____

INDICATION (Please tick)

☐ Clinical Remission ☐ Active Disease

☐ Disease extent ☐ Stricture assessment ☐ Perianal Fistula assessment

Other:……
……
……

IBD CLASSIFICATION (Please circle)

CROHN'S DISEASE

L1: Ileal
L2: Right Colon
L2: Left Colon
L2: Pan colitis
L4: Upper GI
L4: Jejunal
P1: Perianal fistulae
L3: Ileal + right colon
L3: Ileal + left colon
L3: Ileal + pancolitis

ULCERATIVE COLITIS

C1: Procitis
C2: Left sided colitis (to splenic flexure)
C3: Extensive Colitis

CURRENT IBD MEDICATIONS (Please tick)

☐ Prednisolone ☐ Azathioprine (Imuran)
☐ Budesonide ☐ 6MP (Purinethol)
☐ Hydrocortisone ☐ Methotrexate
☐ Sulfasalazine ☐ Infliximab (Remicade)
☐ Mesalazine ☐ Adalimumab (Humira)
☐ Balsalazide ☐ Nil

Other: …….

PREVIOUS SURGERY (Please tick)

☐ Nil
☐ Isolated small bowel resection
☐ Ileocaecal resection
☐ Right Hemicolectomy
☐ Left Hemicolectomy
☐ Subtotal Colectomy

Other……

PLEASE FAX REQUEST SLIP TO 9076 2194. ANY ENQUIRIES PHONE 9076 2223