MELBOURNE BOWEL ULTRASOUND

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PATIENT DETAILS		REFERRING DOCTOR	
FIRST NAME		NAME	
SURNAME		CLINIC NAME	
DATE OF BIRTH		PHONE	
SEX		EMAIL	
MOBILE		PROVIDER No	
		SIGNATURE	
		REFERRAL DATE	

REFERRAL DETAILS

Urgency of scan	Indication	IBD extent	Prior bowel surgery
Urgent	Non IBD	NA: Non IBD	Yes
Within 6 weeks	Crohn's disease (CD)	CD: Ileal	No
Within 3 months	Ulcerative colitis (UC)	CD: Colonic	*If yes, please provide details below*
Within 6 months		CD: Ileocolonic	
		UC: Proctitis	
		UC: Left sided	
		UC: Pancolitis	

CLINICAL QUESTION & OTHER RELEVANT INFORMATION

Please email your completed referral to ***referrals@melbournebowelultrasound.com.au***

Please contact our team if you would like to discuss your referral beforehand.