Dr Margaret Leach - Gastroenterologist

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Please complete and sign, **attach your referral and any relevant blood tests/scans** and return via email/mail.

Have you seen Dr Leach before? No Yes Year? ___________

Surname			Given Name		
Date of Birth			Weight (kg)	Height (cm)	
Address					
Suburb			Post Code		
Mobile			Home		
Email			Occupation		
Relationship Status	Single	Married	De Facto	Widowed	Divorced
Emergency Contact & Phone Number			Relationship to you		
Medicare Number					
Ref. No			M/C expiry date		
Private Health Fund			Membership No		
DVA No			DVA Class		
Pension No			Pension expiry date		

Usual GP		Telephone	
Practice Address			
Suburb		Post Code	
Referring Doctor		Telephone	
Are you taking Warfarin?		Yes	No

MEDICAL HISTORY – patient to complete

Reason for referral			
Do you require a consultation	Yes	No	Unsure
Do you require a procedure only	Yes	No	Unsure
If procedure – which one?	Gastroscopy	Colonoscopy	Both

Have you had or do you currently have any of the following?

Family history of colorectal cancer	Yes	No	Age of relative when diagnosed and relationship to you
Diabetes	Yes	Type	No
Heart Attack	Yes		No
Pacemaker	Yes		No
Heart Murmur	Yes		No
Irregular Heart Beat	Yes		No
Clotting Disorder	Yes		No
Are you on any blood thinners?	Yes		No
Do you smoke	Yes	How many	No
How much alcohol do you drink weekly? (10gms=1 middi beer,1 nip,125ml wine)			
Any other surgery/medical conditions/cardiac history?			
Do you have any allergies- what reaction?			
Have you been vaccinated against Covid-19?	Have you had Covid (date of diagnosis)		
Do you have any special needs?			
Do you have any family history of gastrointestinal disease?			

Please list ALL medication & dosage you are currently taking (incl. supplements/vitamins)

PRIVACY INFORMATION We collect information from you so we can assess, diagnose + treat your illnesses + be proactive in your health care. We will also use the information you provide in the following ways:-Administration of this Medical Practice; Billing, including compliance with Medicare requirements; Disclosure to others involved in your health care, including Drs and Specialists outside this practice who may become involved in treating you (i.e. referral to Drs, tests and in quality studies). I consent to the handling of my information by this practice for the purposes set out above, subject to any limitations on access or disclosure about which I notify this practice now or any future time. I acknowledge that I have read this form before signing it and that a member of the staff of this practice has at my request clarified any aspects of it that I did not understand.

FINANCIAL INFORMATION I also accept financial responsibility for payment of Dr Leach's services and I have read her fee information below. Dr Leach's Consultation Fees: 1st Visit/New Referral $400 or complex 1st visit $500. Follow up visit $180 or complex $210.00. Patients on a disability pension will be bulk billed.

Signed………………………………………………………………………Date……….