LUNG & SLEEP

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Request for Bronchoscopy and EBUS

Patient Details

Name: _____

Address: _____

_____

D.O.B: _____ Sex: □ Male □ Female

Contact: *Phone* _____

Email _____

Medicare No: _____

Health Fund: _____

Memb No: _____

Referring Doctor

Name: _____

Address: _____

_____

Email: _____

Contact Number: _____

Provider Number: _____

Referral Date: _____

Signature: _____

Indication for procedure

_____

Radiology

Provider: _____ Date: _____

Bloods

Provider: _____ Date: _____

INR _____ APTT _____ Platelets _____

Medications

□ Warfarin Date stopped: _____
□ Clopidogrel Date stopped: _____
□ Aspirin Date stopped: _____
□ Other _____

Relevant Medical Conditions

□ COPD □ Asthma
□ Diabetes: □ Insulin □ OHG

□ Other _____

For Proceduralist to complete

Procedure

Booked at: _____ Date: _____

Time of procedure: _____

Time of arrival: _____

Fast from: _____

Scope: _____

Plan

□ Image intensifier □ Not required
□ Anaesthetist: _____
□ Cytologist: □ Booked □ Not required
□ Patient contacted
□ Patient information sent
Follow up with:_____

Notes:

_____

_____