

Peninsula Health

BRONCHOSCOPY BOOKING REQUEST

Phone: 9784 7058 Fax: 9784 2349
email:bronchbookings@phcn.vic.gov.au

UR NUMBER

SURNAME

GIVEN NAMES

DATE OF BIRTH

Please fill in if no Patient Label available App.26/11/2020 Print Code:17520

Patient Details:

Best Contact Phone Number:

Outpatient Inpatient

Patient Email:

Referring Physician: Note: Referrals can be accepted from a Peninsula Health Respiratory Consultant or Respiratory Registrar only.

Name: Contact Number:

Signature: Date of Request:

Clinical Urgency

1 - 2 Weeks 3 - 4 Weeks Referring Specialist's Next Available List Next available list (any specialist)

Health Insurance details

Private Health Insurance No Yes: Fund Name

Procedure:

Indication for Bronchoscopy:

Bronchoscopy

EBUS

Linear

Radial

Biopsy

Endobronchial

Transbronchial

Thermoplasty

Valve insertion / Steam

Additional Requests

Ii required

Scope size: Standard Small Large

Cryo probe required

Additional Information:

Letter from Referring Physician MIA number

Pre Admission completed Capitol

Yes: attached Yes: Patient to return Other

Medical Comorbidities

Anticoagulation / Anti platelet Agents:

Cardiac TB

ID

Diabetes

Type 1 Type 2

Renal CPAP

Haematological BIPAP

Other.....

Aspirin Warfarin

Clopidogrel Enoxaparin

Other..... Direct Oral Anticoagulant

Patient instructions for withholding medications

Patient Instructions:

Overnight bed request



P H F 3 3 5 3 1 6 4 V

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MR/353164