



Eastern Gastroenterology

Patient details:

Name: _____ Date of Birth: ____ / ____ / ____

Address: _____

Phone: _____

Reason for referral:

Clinical Information

Consultation

Gastroscopy

Colonoscopy

Referring practitioner:

Name _____

Address _____

Provider no: _____

Date: ____ / ____ / ____ Signature: _____

Referral to: Any Doctor

Dr Rajesh Bhatia
MBBS, MD, DM, MRCP, FRACP

Dr Stephen Bloom
BMS, MBBS, FRACP

Dr Mayur Garg
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Dr Evan Newnham
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