Transabdominal Gastrointestinal Ultrasound

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Please send completed forms by email to admin@sydneygs.com.au or fax to **02 9804 7149**

Patient's Surname | Patient's First Name | Patient's DOB

Patient's phone number | Patient's Address

Relevant Clinical information AND specific clinical question:

Past Medical History including surgeries | Relevant medications

Referred by | Referral Provider # | Date of referral

Please specify the E-mail address or Fax number for the ultrasound report to be sent to:

This section is signed by the patient at the time of the ultrasound: I understand this is a gastrointestinal ultrasound that will not be assessing other intra-abdominal organs and that the ultimate decision regarding my health will be up to my usual gastroenterologist/referring doctor whom I will return to and discuss these ultrasound results.

Patient's Name | Patient's Signature | Date

Sydney Gastrointestinal Specialists

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