Blackrock Clinic

# Cystoscopy Direct Access Referral

**Patient Details:**

Name _____

Date of Birth _____

Address _____

_____

Telephone _____

Mobile _____

**GP Details:**

Name _____

Practice _____

Address _____

_____

Telephone _____

Mobile _____

**Priority** ☐ URGENT ☐ SOON ☐ ROUTINE

**Medical Insurance** ☐ VHI ☐ IRISH LIFE ☐ LAYA ☐ OTHER ☐ SELFPAY

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## CYSTOSCOPY INDICATIONS

Haematuria ☐ Micro-haematuria ☐

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Duration of Symptoms _____

Past Medical History _____

Current Medications _____

Is patient on: **Warfarin** **Aspirin** **Plavix** **Xarelto** **Pradaxa**

Is the patient on any other blood thinners? _____

Indication for treatment _____

Is the patient Diabetic? **NO** **YES** | Is the patient on Insulin? **NO** **YES**

Has the patient had **Cardiac Surgery / Valve Surgery**? _____

**GP Signature**_____ **Date** _____

**ENQUIRIES: daycare.unit@blackrock-clinic.com** **PLEASE FAX: 01 206 4532**

*Please Note: The following patients should be referred directly to the consultant's secretary:*

*Patients over the age of 75 years | Patients with a significant cardiac history | Diabetic patients on Insulin therapy.*