

- | | |
|---|--|
| <input type="checkbox"/> Dandenong Hospital | <input type="checkbox"/> MMC – Clayton |
| <input type="checkbox"/> Kingston Centre | <input type="checkbox"/> MMC– Moorabbin |
| <input type="checkbox"/> Jessie McPherson | <input type="checkbox"/> Community Health Services |
| <input type="checkbox"/> Casey Hospital | <input type="checkbox"/> Cranbourne Integrated Care Centre |

Unit Record Number:

Surname:

Given Name:

Address:

D.O.B: Age: Sex:

Email:


Procedure Requested:

- Bronchoscopy
- Bronchoalveolar – lavage (BAL)
- Transbronchial lung biopsy **
- Rigid bronchoscopy **
- Vocal cord box injection
- Cryobiopsy **
- Required II
- Linear EBUS **
- Radial EBUS **

 CAT 1
 CAT 2
Infectious Precautions
 Respiratory Contact Nil

State Infection:

Allergies Yes No Details:.....

Interpreter Yes No Language:.....

To be completed by Physiology Registrar
PROCEDURE DATE: ____ / ____ / ____

Triaged by:

Approved by:

**** Referrer to discuss with Proceduralist**
Approved by:**

Clinical Details / Reason for Referral

.....

.....

.....

Radiology	Monash Health	Other Service	Date Performed
CT / HRCT / PET

Pathology

Date: INR: APTT: Platelet: Service used:

 Results attached: Yes No

Anticoagulation

- Nil
- Clexane / Heparin / Warfarin
- Aspirin
- Clopidogrel / Ticagrelor / Prasugrel
- DOAC:

 Contraindications to ceasing anticoagulation

Details:

Date anticoagulation to be ceased ____ / ____ / ____

Diabetes
 Nil Diet controlled OHG Insulin

 Instructions given to patient regarding diabetes management prior to procedure Yes No

Details:

Patient Follow Up

Date ____ / ____ / ____ Clinic: currently inpatient under med oncology clayton

If Lung MDM discussion is required following procedure, please complete Lung MDM referral form
Requesting Doctor
Name: **Signature:**

Contact Details: Date ____ / ____ / ____

 Please email to bronchoscopybookings@monashhealth.org