MonashHealth

- ☐ Dandenong Hospital
- ☐ Kingston Centre
- ☐ Jessie McPherson
- ☐ Casey Hospital
- ☐ Monash Medical Centre Clayton
- ☐ Moorabbin Hospital
- ☐ Community Health Services
- ☐ Cranbourne Integrated Care Centre

Affix Patient Identification Label

Unit Record Number: .....

Surname: .....

Given Name: .....

D.O.B: ..... Age: ..... Sex: .....

Address: .....

.....

PROPOSED DATE .....

Bronchoscopy requested for:

- ☐ Peripheral lung lesion
- ☐ Central lung lesion
- ☐ Mediastinal lesion or lymphadenopathy
- ☐ Diffuse interstitial lung lesion
- ☐ Haemoptysis
- ☐ Infection
- ☐ Other .....

Additional procedure requested:

- ☐ Bronchoalveolar – lavage (BAL)
- ☐ Fluoroscopy
- ☐ EBUS TBNA **
- ☐ Cryobiopsy **
- ☐ Transbronchial lung biopsy **

** **Approved by:** .....

Infectious Precautions

☐ Respiratory ☐ Contact ☐ Nil

State Infection .....

Allergies ☐ Yes ☐ No

Details .....

Interpreter ☐ Yes ☐ No Language .....

Clinical Details

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.....

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Urgency

- ☐ < 1 week
- ☐ 1 – 2 weeks
- ☐ 2 – 4 weeks

Radiology	**MMC**	**Other Service**	**Date Performed**
☐ **CXR**	.....	.....	.....
☐ **CT / HRCT / PET**	.....	.....	.....

If radiology is not MIA or Monash Health, please ensure disc is received at Monash Lung & Sleep prior to procedure

Pathology

Date ..... INR ..... APTT ..... Platelet ..... Service Used .....

Results attached ☐ Yes ☐ No

Anti-coagulation

Warfarin

- ☐ Heparin / Clexane
- ☐ Other

- ☐ **Nil**
- ☐ Aspirin
- ☐ Clopidogrel

Date Anticoagulation Ceased ____/____/____

- ☐ Contraindications to ceasing anticoagulation

Diabetes

☐ Diet controlled ☐ OHG ☐ Insulin

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

Patient Follow Up

Date ___/___/___ Clinic .....

If Lung MDT discussion is required following procedure, please ensure the appropriate referral is sent with all relevant documentation

Requesting Doctor

Name ..... **Signature** .....

Contact Details ..... Date _____/_____/_____

Please fax referral to **9594 6311** or email to **bronchoscopybookings@monashhealth.org** and call **9594 2774** to confirm referral has been received

REQUEST FOR FIBREOPTIC BRONCHOSCOPY / EBUS

MRD24