

Christchurch Gastroenterology Group

Dr Steven L Ding

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Patient Details:

Patient's Surname: _____

First names: Mr / Mrs / Ms / Miss _____

Address: _____

Telephone: Home _____ Work _____ Date of Birth: / /

- For:** Consultation
 Gastroscopy
 Colonoscopy

Clinical Details:

Comorbid conditions:

- Cardiac _____
 Respiratory _____
 Diabetes mellitus _____
 Other _____

Drugs:

- Warfarin Aspirin/NSAIDS
 Other _____

 Allergies / anaesthetic problems

Referring Doctor: (or stamp)

Signature _____ Date: / /