

Central Adelaide Gastroenterology and Hepatology Services

Clinical Information Sheet

ALTERED BOWEL HABIT	Clinical Presentation/syndrome
Eligibility	New onset constipation and/or diarrhoea
Information required with referral	<p><u>History of altered bowel habit must include:</u></p> <ol style="list-style-type: none"> 1. Describe normal bowel habit for patient & specify what the change is 2. Onset - sudden vs gradual 3. History of any travel +/- antibiotics 4. Other family members/friends affected 5. ? Episodes previously investigated for similar symptoms - ?When - Send details/results 6. Character – <ol style="list-style-type: none"> a. Consistency b. volume c. mucus d. blood e. pain f. need to strain 7. Family history – especially: CRC cancer, IBD, coeliac disease, IBS 8. Medications - especially laxatives 9. Associated symptoms: <ol style="list-style-type: none"> a. weight loss b. pain c. rectal bleeding 10. Previous relevant GI surgery &/or treatment <p><u>Examination</u> Relevant findings, <u>including</u> PR exam</p>
Investigations required with referral	<ul style="list-style-type: none"> • Blood tests: CBE, CRP, Coeliac serology + TFTs (if loose stools), iron studies, biochemical screen including albumin • Faecal M,C & S Consider doing faecal calprotectin if loose stools for <u>>6 weeks</u>. <p><u>NOTE: FHH testing is a screening test for ASYMPTOMATIC individuals >50 years of age who are at AVERAGE risk of colorectal cancer. FHH testing should NOT be done to investigate a change in bowel habit.</u></p>

For more information

Central Adelaide Gastroenterology and Hepatology Services:

Royal Adelaide Hospital, North Terrace, Adelaide. Telephone: 08 8222 4000

The Queen Elizabeth Hospital, 28 Woodville Road, Woodville South. Telephone: 08 8222 6000

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