Capital Health

Unit Number Bar Code

Division of Digestive Care & Endoscopy

# Referral Form

**Referral Office:**
Tel: (902) 473-7833; Fax: (902) 473-4406

**REFERING PRACTITIONER'S NAME:** _____ **FAX NUMBER:** _____

## PATIENT INFORMATION

Name:

Mailing address:

Phone number:

Date of birth:

☐ Male ☐ Female

Health card number:

1. Has your patient been assessed by a gastroenterologist before?
☐ No ☐ Yes – **please attach relevant details (e.g., consults)**

2. Has your patient undergone upper endoscopy in the past?
☐ No ☐ Yes – **please attach relevant details (e.g., reports)**

3. Has your patient undergone lower endoscopy in the past?
☐ No ☐ Yes – **please attach relevant details (e.g., reports)**

4. If repeat endoscopy is required, is your patient willing to come direct to procedure?
☐ No ☐ Yes – **please complete relevant sections on page 2**

**5.** Are you requesting a specific gastroenterologist/hepatologist?
☐ No ☐ Yes – **please provide your 1st/2nd choice:**

_____

## REASON FOR REFERRAL

**What is the specific question you want answered regarding your patient?**

**Please help us manage our referrals properly: check all relevant findings below**
**Attach additional page(s) as necessary to facilitate and enhance consultation**

**Upper GI Symptoms**
- ❑ Decreased appetite
- ❑ Dysphagia
- ❑ Early satiety
- ❑ Epigastric pain
- ❑ GERD more than 10 years
- ❑ GERD, refractory to PPI more than 2 months
- ❑ Hematemesis/Coffee grounds
- ❑ Melena
- ❑ Non cardiac chest pain
- ❑ Odynophagia
- ❑ Persistent vomiting

**Other indication(s):**

**Lower GI Symptoms**
- ❑ Acute diarrhea < 2 weeks
- ❑ Change in bowel habit
- ❑ Chronic abdominal pain
- ❑ Chronic constipation
- ❑ Chronic diarrhea > 1month
- ❑ IBS symptoms, no alarm features
- ❑ Rectal bleeding, result of DRE:
- ❑ Weight loss NYD

**Abnormal Investigations**
- ❑ Drop in hemoglobin
- ❑ Iron deficiency anemia
- ❑ Positive FOBT/FIT
- ❑ Positive TTG
- ❑ Abnormal diagnostic imaging

**Follow up of prior GI diagnosis**
- ❑ Barrett's esophagus
- ❑ Crohn's disease
- ❑ Ulcerative colitis
- ❑ Polyps

**Colon cancer screening**
- ❑ 1st degree relative under 60 years
- ❑ 2 or more 2nd degree relatives (one must be under 60 years)
- ❑ FAP/Attenuated FAP
- ❑ HNPCC

**Hepatology**
- ❑ Ascites +/- jaundice
- ❑ Elevated liver enzymes +/- prolonged INR
- ❑ HBV or HCV
- ❑ Fatty liver on diagnostic imaging

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**All Gastroenterology & Hepatology Consultations at the QE2 must be received on this form.**
**Direct Referrals for ERCP *do not* require this form.**

**Incomplete forms will be returned. Request for additional information may be necessary.**
**Avoid delays by attaching all pertinent laboratory test, abnormal investigations, prior relevant consultations, and prior endoscopy reports/pathology. All Referrals for GI bleeding must include most recent CBC and Ferritin.**

| **CURRENT MEDICATION LIST:** □ None | **For DC&E Office Use Only** | |
|---|---|---|
| | Reviewed by: | Date: |
| | Consult category: C1 C2 C3 | Endoscopy category: E1 E2 E3 |
| | Book for direct **Remote Specialist Telephone Advice** | |
| | Book for direct **Colonoscopy** **Flexible sigmoidoscopy** **Gastroscopy** | |
| | Appt with: | |
| | Appt Time: | Appt Date: |
| | Booked by: | Date: |
| | Patient notified by: | Date: |
| | Patient contacted by: phone mail fax | |
| | Practitioner notified by: | Date: |
| | Practitioner contacted by: phone mail fax | |
| **DRUG OR LATEX ALLERGY:** □ None | | |

## ADDITIONAL INFORMATION REQUIRED FOR DIRECT ENDOSCOPY

| **Does your patient take:** | | **Does your patient have:** CHECK ALL THAT APPLY |
|---|---|---|
| **Coumadin (Warfarin)** | □ Yes □ No | □ **Abnormal Renal Function** – ***Most recent creatinine level:*** |
| **Plavix (Clopidogrel)** | □ Yes □ No | □ **Severe pulmonary disease or NYHA heart failure > class II** |
| **Aspirin or NSAIDs** | □ Yes □ No | □ **Diabetes mellitus on medication:** □ ***Oral Hypoglycemic*** □ ***Insulin*** |
| **Fragmin (Dalteparin)** | □ Yes □ No | □ **Previous abdominal/pelvic surgery** |
| **Pradax (Dabigatran)** | □ Yes □ No | □ **History of adverse reaction to sedation/anesthesia** |
| **Xarelto (Rivaroxaban)** | □ Yes □ No | □ **History of inherited bleeding disorder** |
| **Arixtra (Fondaparinux)** | □ Yes □ No | □ **Cognitive impairment/communication difficulties** |