West Coast Gastroenterology

Central Intake Referral Form

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Patient Demographic Information	**Referring Provider Information**
Last Name: First Name: PHN: DoB (mm/dd/yyyy): Gender: ☐ M ☐ F ☐ O Primary/Secondary Phone(s): Email: Full Mailing Address: City: Post Code:	Provider Name: MSP #: Clinic Name: Clinic Address: Clinic Phone: Clinic Fax: Referral Desk #: **GP Name (if not referring provider):**
Referral Date (mm/dd/yyyy):	**Prior visit to a Gastroenterologist / Endoscopist?**
☐ **Refer to the first available specialist** **(*Patients previously seen in this clinic will be triaged to the original GI*)** ☐ Prefers to see Dr._____ (1st choice of specialist not guaranteed)	☐ Yes, previously saw Dr._____ ***Please attach reports (consult, procedure reports, pathology)***

REASON FOR REFERRAL : check appropriate box below

CATEGORY A (Target <14 days)	**CATEGORY B (Target 90 days)**	**CATEGORY C (Target > 1 year)**
☐ High likelihood of cancer based on clinical symptoms, physical exam and imaging ☐ Inflammatory Bowel Disease (active – new diagnosis or flare-up) ☐ Progressive dysphagia or odynophagia ☐ Jaundice ☐ New liver mass / cancer ☐ Need for EUS / ERCP ☐ Pancreatitis ☐ Pancreas lesion follow-up ☐ Immunotherapy related adverse event	☐ Recurrent or persistent rectal bleeding ☐ Iron deficiency anemia ☐ Positive FIT ☐ Stable dysphagia ☐ Diarrhea >14 days ☐ Hepatitis / Cirrhosis / Chronic Liver Disease ☐ Abnormal liver enzymes ☐ NASH ☐ Abnormal imaging requiring endoscopic evaluation ☐ Inflammatory Bowel Disease – stable ☐ Celiac disease ☐ Severe GERD/dyspepsia ☐ Severe abdominal pain ☐ New change in bowel habits	☐ Screening or surveillance colon Cancer ☐ Barrett's esophagus screening ☐ Chronic constipation/diarrhea ☐ Irritable Bowel Syndrome (IBS) ☐ Chronic GERD/dyspepsia ☐ Chronic abdominal pain ☐ Chronic nausea/vomiting ☐ Bloating, gas ☐ Request for 2nd opinion

Additional Information:

Clinical Warnings : check appropriate boxes below	**Supporting Documents** (blood-work, microbiology, diagnostic imaging, histopathology, consultants letters)
☐ Morbid Obesity ☐ Mobility Impairment ☐ Cognitive Impairment ☐ CKD ☐ Diabetes ☐ MRSA / VRE ☐ **Anticoagulation and/or antiplatelet agent** ☐ ICD cardioverter-defibrillator ☐ Allergies:_____ ☐ Interpreter Required (specify language): _____	☐ None ☐ Attached ☐ Pending _____ Relevant Medical History: ☐ Attached ☐ None Current Medications: ☐ Attached ☐ None

IMPORTANT

INCOMPLETE REFERRAL FORMS AND THOSE LACKING SUPPORTING DOCUMENTATION WILL RESULT IN A DELAY IN PROCESSING.

Fillable forms are available on pathwaysbc.ca

Fax patient referrals individually, not as a batch containing multiple patient referrals

We will fax a confirmation of receipt within 7 days.