Thunder Bay Regional Health Sciences Centre

ENDOSCOPY & COLONOSCOPY REFERRAL

Place Patient Label with Barcode Here

Guidelines:

1. Physician or Nurse Practitioner to complete referral.
2. **Fax to Endoscopy and Colonoscopy Central Intake at 855-610-2254.**
3. A detailed letter can be sent in lieu of this form provided the letter clearly contains all the necessary information requested on the form
4. Incomplete or illegible referrals will be declined back to the referring provider.
5. Questions - contact the Endoscopy and Colonoscopy Central Intake and Assessment Program at **807-684-7103**

PATIENT INFORMATION **DATE:**

Last Name, First Name: _____ Date of Birth (day/month/year) _____ Age_____

Sex ☐ Female ☐ Male ☐ Unspecified Health Card Number: _____ Version Code: _____

Address _____ Telephone: Home _____

_____ Postal Code: _____ Work _____ Cell _____

Does the patient have a Family Physician or Nurse Practitioner? ☐ Yes ☐ No WSIB Claim Number _____

Primary Contact (Last Name, First Name): _____

Relationship to Patient: _____ Phone Number: _____

☐ Patient incapable of giving his/her own Informed Consent: legally appointed representative_____

☐ Patient to be accompanied by an interpreter at the time of appointment if they do not read/speak English.

ENDOSCOPY (EGD): ☐ Next available appointment ☐ Urgent

Indications for direct to EGD

☐ Esophageal dysphagia

☐ Barrett's surveillance

Indications for consultation and potential EGD

☐ GERD despite PPI

Please provide details of symptoms or any other relevant information that will assist with triage:

COLONOSCOPY: ☐ Next available appointment ☐ Urgent

Indications for direct to colonoscopy

Symptomatic:

☐ Persistent or new rectal bleeding

☐ Narrowing of stool diameter

☐ Iron deficiency anemia: please attach recent CBC, ferritin, and any other iron studies

Screening (DAP):

☐ Abnormal FIT (patient 50-74yrs): Test Date: _____ (Please attach results)

☐ First degree family history of colorectal cancer (patient < 74yrs): Relative and age relative diagnosed:_____☐ <60yrs ☐ >60yrs

☐ Surveillance: Date of last two colonoscopies: _____

Indications for consultation and potential colonoscopy

☐ Abdominal pain

☐ Changes to bowel movements

☐ Weight loss

Please provide details of symptoms or any other relevant information that will assist with triage:

TREFENDOCOLON

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Preferred Endoscopist: ☐ NO ☐ YES If yes, please specify: _____ Preferred Site: TBRHSC ☐ Marathon ☐

***FIT positive referrals will be assigned next available endoscopist to meet timeline guidelines**

Please answer yes or no: Anticoagulant / Antiplatelet / ASA/ NSAID ☐ YES specify: _____ ☐ NO
Recent cardiac stent insertion in the last 12 months ☐ YES: Cardiologist: _____ ☐ NO

Please include relevant diagnostic reports, relevant medical history and CURRENT medication list with ALL referrals

PHYSICIAN INFORMATION/ NURSE PRACTITIONER INFORMATION

I confirm this patient has given consent to being booked direct to EGD and/ or Colonoscopy ☐

Name: **Phone:**

Signature: **Fax:**

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