

KAMLOOPS GASTROENTEROLOGY REFERRALS

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Date of Referral (DD/MM/YY):			
PATIENT INFORMATION		REFERRING PRACTITIONER	
Patient Name (Last, First):		Referring Provider:	
Patient Address:		Clinic Name:	
		MSP #:	
Patient PHN:		Clinic Phone:	
DOB (DD/MM/YY):		Clinic Fax:	
Patient Phone:		Family Provider:	
Alternate Phone:		Copy to:	
GASTROENTEROLOGIST REQUESTED			
☐ First Available ☐ Patient prefers to see: (Patients previously seen in this clinic will be triaged to the original GI)		☐ Previous Patient of:	
PRIOR ENDOSCOPY WITHIN LAST TWO YEARS*			
☐ Yes (please attach report)	□No	*Patients with recent endoscopy	may be triaged as a second opinion.
REFERRAL TYPE			
Emergent (Target: 2 weeks)	Urgent (Target: 8 weeks)	Semi-urgent (Target: 12 weeks)	Elective (Target: 6 months)
☐ Anemia with hematemesis/coffee ground emesis	☐ Lower GI bleeding	☐ Chronic viral hepatitis/cirrhosis	☐ Screening colonoscopy
☐ High probability of malignancy based on imaging/exam	☐ Positive FIT (Outside CSP program)	☐ Celiac disease	☐ Screening gastroscopy
☐ Severe/progressive dysphagia	☐ Iron deficiency anemia	☐ Severe dyspepsia/abdominal pain	☐ Inflammatory bowel disease (stable)
☐ Active inflammatory bowel disease	☐ Decompensated cirrhosis	☐ New chronic diarrhea	☐ Stable chronic abdominal pain
☐ Painless jaundice		☐ New chronic constipation	☐ Abnormal liver enzymes
		☐ Stable dysphagia	☐ Chronic GERD/dyspepsia
			☐ Second opinion
REASON FOR REFERRAL (or include	separate consult letter)		
To facilitate accurate triage please attach: Past medical history and current medications Relevant investigations			
☐ Translator required for this language:	☐ Diabetic requiring medications	☐ Cognitive Impairment	☐ Major psychiatric disease
Active or unstable cardiac or pulmonary disease	☐ Obesity	☐ Anticoagulation:	☐ Antiplatelet agent:
OFFICE USE ONLY			

^{***} Please note: Incomplete referrals will be returned.