



Dr. Twila Burgmann | Dr. Joel Emery | Dr. Muhammad Laghari | Dr. Eugene Lee | Dr. Josh Nero | Dr. Taralyn Picton

Date of Referral (DD/MM/YY):

PATIENT INFORMATION		REFERRING PRACTITIONER	
Patient Name (Last, First): Patient Address: Patient PHN: DOB (DD/MM/YY): Patient Phone: Alternate Phone:		Referring Provider: Clinic Name: MSP #: Clinic Phone: Clinic Fax: Family Provider: Copy to:	
GASTROENTEROLOGIST REQUESTED			
☐ First Available (Patients previously seen in this clinic will be triaged to the original GI) ☐ Patient prefers to see: ☐ 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) ☐ Anemia with hematemesis/coffee ground emesis ☐ High probability of malignancy based on imaging/exam ☐ Severe/progressive dysphagia ☐ Active inflammatory bowel disease ☐ Painless jaundice	Urgent (Target: 8 weeks) ☐ Lower GI bleeding ☐ Positive FIT (Outside CSP program) ☐ Iron deficiency anemia ☐ Decompensated cirrhosis	Semi-urgent (Target: 12 weeks) ☐ Chronic viral hepatitis/cirrhosis ☐ Celiac disease ☐ Severe dyspepsia/abdominal pain ☐ New chronic diarrhea ☐ New chronic constipation ☐ Stable dysphagia	Elective (Target: 6 months) ☐ Screening colonoscopy ☐ Screening gastroscopy ☐ Inflammatory bowel disease (stable) ☐ Stable chronic abdominal pain ☐ Abnormal liver enzymes ☐ 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: _____ ☐ Active or unstable cardiac or pulmonary disease			
☐ Diabetic requiring medications ☐ Obesity ☐ Cognitive Impairment ☐ Major psychiatric disease ☐ Anticoagulation: ☐ Antiplatelet agent:			
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