Comox Valley Direct to Endoscopy Program

(CVDTE) Fax number (250) 331-8688

Patients below the age of 17 or above the age of 75 will not be accepted into the program.

A. PATIENT INFORMATION			**B. SEND RESULTS TO**
Last name			Referring Physician
Given name (s)			
Date of birth Day Month year		Patients age	MSP# ☐ This is the Primary Care provider
PHN		Patients sex ☐M ☐F ☐X	Clinic name Street Address STAMP HERE Phone Fax
Primary contact number			
Special instructions			
Email (optional)			
Street address			Family Physician (if different from referring physician)
City	Prov	Postal code	
Translator required ☐Yes ☐No If yes, patients first language			Copy to (Full name)

C. Procedure(s) Requested (indicate All that apply)

☐ Gastroscopy ☐ Colonoscopy

D. Prior Endoscopies

☐No ☐Yes If yes, include most recent endoscopy/pathology (within 5 years)

E. Reason For Referral (required results listed in bold)

(Document in space provided Below-NOT as separate attachment:

EMERGENT: Procedure (arrange with on-call surgeon) (acute GI bleed, esophageal food bolus, foreign body and obstructive jaundice)

GUIDELINES FOR DETERMINING LEVEL OF URGENCY FOR GI REFERRAL	
Urgent 2 Weeks	**Non Urgent 26 Weeks**
☐Severe or rapidly progressive dysphagia	☐Barrett's **(include most recent gastroscopy/pathology)**
☐High Likelihood of CA based on imaging or physical exam **(radiology report)**	☐Family hx colon CA (1^0 relative <60yr, or two 1^0) not meeting CSP criteria
Urgent 4 Weeks	☐Prior polyps not meeting CSP criteria **(include pathology and colonoscopy note**
☐Iron Deficiency anemia **(CBC, Ferritin, anti-tTG, MCV)**	
☐Clinical features suggestive of active Inflammatory Bowel Disease	☐Prior colon CA **(include pathology and colonoscopy note)**
Semi Urgent 8 Weeks	☐Inflammatory bowel disease requiring surveillance (**include GI report if available**)
☐Stable Dysphagia	
☐Rectal Bleeding	* Surveillance referrals greater than 6 months before surveillance due date cannot be accepted
☐+Fit (not meeting CSP criteria) **(FIT results)**	
☐Confirmation of celiac disease **(positive anti-tTG and IgA)**	
☐Change in Bowel Habits If Diarrhea include **C. difficile, GPMP and Anti-tTG**	

Clinic to acknowledge receipt of referral by faxing ☐Acceptance letter or ☐Incomplete/returned letter

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F. Criteria

CVDTE is a centralized referral program that stream lines **requests for GI ENDOSCOPY** at Comox Valley Hospital (CVH).

1. Requests for emergent procedures must be arranged with the on-call surgeon (acute GI bleed, esophageal food bolus, foreign body)
2. **NOT Eligible** for CVDTE referral: **Patients who are on dual antiplatelet medication, cardiac stents <6 months, stroke/MI <3 months, need for bridging heparin, patients who have an ICD.**
3. Candidates that meet BC Colon Screening Program (CSP) guidelines should be referred to the CSP program. http: / / www.bccancer.bc.ca / screening / health-professionals / colon / eligibility
4. Referrals for office assessment/consultation should be directed to individual specialist's office.

PLEASE ATTACH ELECTRONIC Medication, Physical and Medical History OR FILL OUT BELOW

G. Medications

☐ NO Medications

Anticoagulation/antiplatelet	☐Yes	☐No	Drug and indication:
Diabetic (oral/insulin)	☐Yes	☐No	Drug and indication:
Iron	☐Yes	☐No	Drug and indication:
Blood Pressure	☐Yes	☐No	Drug and indication:

If patient on medication, please attach list.

Allergies ☐Yes ☐No If yes, include details

H. Physical Exam

To ensure a rapid triage, assessment, and safety of the patient it is imperative that the following be included in the medical history if it pertains to the patient.

In office Rectal Exam Completed: ☐Normal ☐Findings comment:

Height cm:_____ Weight kg:_____ BMI:_____

I. Medical History

Previous stroke	☐Yes	☐No	If yes, include details
Pacemaker/defibrillator	☐Yes	☐No	If yes, include details
Mechanical Heart Valve/stent(s)	☐Yes	☐No	If yes, include details
Previous MI	☐Yes	☐No	If yes, include details
Congestive Heart Failure	☐Yes	☐No	If yes, include details
Sleep apnea	☐Yes	☐No	CPAP ☐Yes ☐No
COPD	☐Yes	☐No	If yes, include Severity ☐Mild ☐Moderate ☐Severe
Home Oxygen	☐Yes	☐No	
Renal impairment (eGFR <30))	☐Yes	☐No	If yes, include recent eGFR
Diabetes Type I Type II	☐Yes	☐No	If yes, include details
Cirrhosis	☐Yes	☐No	If yes, include details

Other Chronic Medical Condition not listed above:

Surgical History (include dates):

Patients Last name	DOB
Patients Given name (s)	PHN

J. Supporting Documents: (bloodwork, microbiology, diagnostic imaging, histopathology, consultants letters)

☐None ☐Attached ☐Pending:_____

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