Campbell River Direct to Endoscopy Program
(CRDTE) FAX Number 250-286-7115

A. PATIENT INFORMATION			B. SEND RESULTS TO
Last name			Referring Physician
First name			
Date of birth Day Month Year		Patient age	MSP# ☐ This is the Primary Care provider
PHN		Patients sex ☐M ☐F ☐X	Clinic name
Primary contact number			Street Address STAMP HERE
Special instructions			Phone
Email (optional)			Fax
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 ☐ Flexible sigmoidoscopy +/- Banding

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

(Document in space provided)

Urgent 8 Weeks	**Non Urgent 26 Weeks**
☐Iron deficiency anemia**(CBC, Ferritin, anti-tTG, IgA)**	☐Dysphagia-stable/slow progression
☐Radiologic suspicion of CA **(radiology report)**	☐Barrett's **(include most recent gastroscopy/pathology)**
☐Blood mixed WITHIN stool	☐Chronic GERD **(>5y, no prior gastroscopy)**
	☐Prior colon CA **(include pathology and colonoscopy note)**
Semi Urgent 12 Weeks	☐Family hx colon CA (1^0 relative <60yr, or two 1^0) not meeting CSP criteria
☐Celiac confirmation **(anti-tTG and IgA)**	☐Prior polyps not meeting CSP criteria**(include pathology and colonoscopy note)**
☐Diarrhea >6 weeks **(anti-tTg, GPMP)**	☐+Fit not meeting CSP criteria **(FIT results)**
☐Constipation >6 weeks	**Inflammatory Bowel Disease**
☐outlet bleeding (blood on tissue or in toilet)	☐Inflammatory bowel disease requiring surveillance (include GI report if available)

E. Prior Endoscopies (If Surveillance Please send referrals within 6 months of due date)

☐ Yes ☐ No If yes, **was previous endoscopy done in VIHA** ☐ Yes ☐ No

F. Preferred Endoscopist

Requested Endoscopist: ☐ Next Available ☐ Specified_____

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

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AN ELECTRONIC GENERATED REFERRAL LETTER CAN BE ATTACHED INSTEAD OF FILLING OUT THIS PAGE, ENSURE ALL INFORMATION IS INCLUDED

G. Medication (referral will be returned if not completed)

☐ No Medication

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:

List all other medications that are not listed above, or attach list:

NOAC's (e.g. Pradaxa, Eliquis, etc.) stop 3 days prior to procedure; Warfarin 5 days; Antiplatelets (e.g. Plavix, etc.) 7 days.
Iron stop 7 days; Diabetic Medication and insulin to be held morning of procedure.

Allergies ☐Yes ☐No If yes, include details

H. Physical exam

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

Height cm:_____ Weight kg:_____ BMI:_____

I. Medical Information

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

Other Chronic Medical Condition not listed above:

Surgical History (include dates):

Last name	Date of birth Day Month Year
First name	PHN

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Required Medical Information

The following **MUST** be included with the CRDTE referral form or the referral will be returned and closed:

1. As per College of Physicians and Surgeons of BC, referrals must include the following:
   a. A letter providing clinical history and reason for referral
   b. List of current medications
   c. List of patient's medical conditions
2. All lab results and documents indicated in Sections **E, F, H, I and J must be included with referral**.

CRDTE Timelines

CRDTE acknowledges, accepts or rejects referrals in the following manner and timelines:

1. **Accepted referrals will be acknowledged by Acceptance Letter within 14 business days.** If you do not receive an Acceptance Letter within 14 business days, please notify CRDTE **by fax**.
2. Incomplete referrals, or referrals lacking requested results/documents, will be returned and considered closed. **If a referral is returned, you will receive notification via Rejection Letter within 14 business days.** If a referral is rejected, a **NEW REFERRAL** will need to be submitted to CRDTE, along with the missing documents.
3. If you have any questions regarding the completion of the referral form, contact the CRDTE Office at **250-286-7171**.

Suitable for Direct to Scope:

1. Presumed able to follow pre procedure instruction and bowel prep when applicable
2. Patient cognitively intact and agreeable to procedure
3. Absence of major medical illness requiring assessment
4. Patients on dual antiplatelets, cardiac stents less than 6 months, stroke/MI less than 3 months and need for bridging heparin are NOT appropriate for the CRDTE program please send referrals to surgeon's office.

Referring Clinician:

SIGNATURE _____ PRINTED NAME AND DESIGNATION _____

Last name	Date of birth Day Month Year
First name	PHN

Criteria

CRDTE is a centralized referral program that streamlines **requests for GI ENDOSCOPY** at Campbell River General (CRG).
Referred patients must meet the following criteria.

1. **Referrals must only be for non-emergent (> 3 weeks) GI endoscopy.** Requests for emergent procedures (within 3 weeks) must be arranged with on-call surgeon (e.g. high likelihood CA, severe dysphagia, active IBD, obstructive jaundice, severe Dysphagia).
   - By calling the CRG switchboard at 250-286-7100
2. **Candidates for colonoscopy with BC Colon Screening Program (CSP) will be RETURNED** to the referring Physician.
   - http://www.bccancer.bc.ca/screening/health-professionals/colon/eligibility
3. Referrals for office assessment/consultation alone should be directed to individual specialist's offices.

THIS SECTION WILL BE COMPLETED BY CRDTE PROGRAM

Referral	Accepted/Rejected letter sent to family doctor	Triage completed By	Referral sent to for assessment	Comments
☐ Accepted ☐ Rejected	☐ yes	☐ Surgeon ☐ Triage Nurse ☐ Clerical	☐ Surgeon office _____ ☐ Triage Nurse ☐ CSP office	
Date:	Date:	Date:	Date:	Date:

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