

A. PATIENT INFORMATION			B. SEND RESULTS TO	
Last name			Referring Physician	
First name			MSP# <input type="checkbox"/> This is the Primary Care provider	
Date of birth Day Month Year			Clinic name	
PHN			Street Address STAMP HERE	
Primary contact number			Phone	
Special instructions			Fax	
Email (optional)			Family Physician (if different from referring physician)	
Street address			Copy to (Full name)	
City	Prov	Postal code		
Translator required <input type="checkbox"/> Yes <input type="checkbox"/> No <small>If yes, patients first language</small>				
C. Procedure(s) Requested (indicate All that apply)				
<input type="checkbox"/> Gastroscopy <input type="checkbox"/> Colonoscopy <input type="checkbox"/> Flexible sigmoidoscopy +/- Banding				
D. Preferred Endoscopist				
Requested Endoscopist: <input type="checkbox"/> Next Available <input type="checkbox"/> Specified _____				
E. Reason For Referral (required results listed in bold)				
Urgent 8 Weeks		Non Urgent 26 Weeks		
<input type="checkbox"/> Iron deficiency anemia(CBC, Ferritin, anti-tTG, IgA)		<input type="checkbox"/> Dysphagia-stable/slow progression		
<input type="checkbox"/> Radiologic suspicion of CA (radiology report)		<input type="checkbox"/> Barrett's (include most recent gastroscopy/pathology)		
<input type="checkbox"/> Blood mixed WITHIN stool		<input type="checkbox"/> Chronic GERD (>5y, no prior gastroscopy)		
Semi Urgent 12 Weeks		<input type="checkbox"/> Prior colon CA (include pathology and colonoscopy note)		
<input type="checkbox"/> Celiac confirmation (anti-tTG and IgA)		<input type="checkbox"/> Family hx colon CA (1 ^o relative <60yr, or two 1 ^o) not meeting CSP criteria		
<input type="checkbox"/> Diarrhea >6 weeks (anti-tTg, GPMP)		<input type="checkbox"/> Prior polyps not meeting CSP criteria (include pathology and colonoscopy note)		
<input type="checkbox"/> Constipation >6 weeks		<input type="checkbox"/> +Fit not meeting CSP criteria (FIT results)		
<input type="checkbox"/> outlet bleeding (blood on tissue or in toilet)		Inflammatory Bowel Disease		
		<input type="checkbox"/> Inflammatory bowel disease requiring surveillance (include GI report if available)		
F. Prior Endoscopies				
<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, was previous endoscopy done in VIHA <input type="checkbox"/> Yes <input type="checkbox"/> No				
G. 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.				
<ol style="list-style-type: none"> 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). <ul style="list-style-type: none"> • 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. <ul style="list-style-type: none"> • 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. 4. NOT Eligible for CRDTE referral: Patients who are on dual antiplatelet medications, cardiac stents < 6 months, stroke/MI < 3 months, need for bridging heparin. 				



Campbell River Direct to Endoscopy Program

(CRDTE) FAX Number 250-286-7115

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

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

No Medication

Anticoagulation/antiplatelet	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Drug and indication:
Diabetic (oral/insulin)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Drug and indication:
Iron	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Drug and indication:
Blood Pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> 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

I. Physical exam

In office Rectal Exam Completed: Normal Findings comment:

Height cm: _____ Weight kg: _____ BMI: _____

J. Medical Information

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

Other Chronic Medical Condition not listed above:

Surgical History (include dates):



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

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 are **NOT** appropriate for the CRDTE program please send referrals to surgeon's office.

Referring Clinician:

SIGNATURE

PRINTED NAME AND DESIGNATION

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
<input type="checkbox"/> Accepted <input type="checkbox"/> Rejected	<input type="checkbox"/> yes	<input type="checkbox"/> Surgeon <input type="checkbox"/> Triage Nurse <input type="checkbox"/> Clerical	<input type="checkbox"/> Surgeon office <hr style="width: 100%;"/> <input type="checkbox"/> Triage Nurse <input type="checkbox"/> CSP office	
Date:	Date:	Date:	Date:	Date: