



## WRHA Referral Form for Endoscopy

(Gastroscopy, Colonoscopy, Flexible Sigmoidoscopy)

Date of Referral:  D D M M M Y Y Y Y

### Patient Information

Mailing Address: \_\_\_\_\_

Non Manitoba Patient Health Card: \_\_\_\_\_

Phone # where message can be left:  -  -  -  -

Alternate Phone #:  -  -  -

Emergency Contact: \_\_\_\_\_

Emergency Contact Phone #:  -  -  -

Language:  English  Other: \_\_\_\_\_

Requires a translator (indicate language) \_\_\_\_\_

### Current Medications (or attach medication list)

Antiplatelet Therapy: \_\_\_\_\_

Oral Anticoagulant: \_\_\_\_\_

Injectable Anticoagulant: \_\_\_\_\_

Oral Hypoglycemic: \_\_\_\_\_

### Referring Clinician

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone #:  -  -  -

Fax #:  -  -  -

### Family Physician (if different from referring physician)

Name: \_\_\_\_\_

Phone #:  -  -  -

Fax #:  -  -  -

No Medications

Acetylsalicylic Acid (Aspirin)  Iron

NSAIDS  Steroids

Blood Pressure  Immunosuppressant

Insulin  Other: \_\_\_\_\_

### Previous Endoscopic Procedure(s) (Attach reports of previous endoscopies, if available)

Colonoscopy      Date:  D D M M M Y Y Y Y      Comments: \_\_\_\_\_

Gastroscopy      Date:  D D M M M Y Y Y Y      Comments: \_\_\_\_\_

Flexible Sigmoidoscopy      Date:  D D M M M Y Y Y Y      Comments: \_\_\_\_\_

### Medical History - up to date (see attached if applicable) No significant medical history

Include all pertinent lab and diagnostic information (see page 3)

<input type="checkbox"/> CHF	<input type="checkbox"/> Pacemaker/Defibrillator	<input type="checkbox"/> Cirrhosis	<input type="checkbox"/> Type I Diabetes
<input type="checkbox"/> IHD	<input type="checkbox"/> Atrial Fibrillation	<input type="checkbox"/> Compensated	<input type="checkbox"/> Type II Diabetes
<input type="checkbox"/> Post MI	<input type="checkbox"/> PE/DVT	<input type="checkbox"/> Decompensated	<input type="checkbox"/> Prosthetic Hardware
<input type="checkbox"/> Coronary Artery Stent	<input type="checkbox"/> Post Stroke	<input type="checkbox"/> Renal Insufficiency	<input type="checkbox"/> Dementia
<input type="checkbox"/> Valvular Heart Disease	<input type="checkbox"/> COPD	<input type="checkbox"/> Dialysis	<input type="checkbox"/> Unable to sign consent
<input type="checkbox"/> Mechanical Valve Replacement	<input type="checkbox"/> Sleep Apnea	<input type="checkbox"/> Creatinine: _____	<input type="checkbox"/> Mobility Concerns (specify): _____
<input type="checkbox"/> Cancer (type): _____			
<input type="checkbox"/> Other concerns: _____			

Date of Diagnosis:  D D M M M Y Y Y Y

Height (cm): \_\_\_\_\_ Weight (kg): \_\_\_\_\_ BMI: \_\_\_\_\_ Blood Pressure: \_\_\_\_\_ Pulse: \_\_\_\_\_

Allergies: \_\_\_\_\_

ASA Classification:  1  2  3  4  5  
Infection Control:  MRSA  VRE  ESBL  C. difficile  Other: \_\_\_\_\_

### Patient Preference

Refer to the next available specialist  
 Provider or patient prefers a specific specialist: \_\_\_\_\_

### Healthcare Provider Review

The procedure indications have been discussed with the patient  
 Additional information is included with this referral, where applicable  
 Patient is not suitable to go direct to scope (see reasons on page 3)

Referring Clinician:

SIGNATURE

PRINTED NAME AND DESIGNATION



Winnipeg Regional Health Authority      Office régional de la santé de Winnipeg  
*Caring for Health*      *À l'écoute de notre santé*

## WRHA Referral Form for Endoscopy

### (Gastroscopy, Colonoscopy, Flexible Sigmoidoscopy)

**Fax Completed form to Endoscopy Central Intake at 204-940-2030**

### **Reason for Referral**

Indicate all that apply including duration of symptoms.

Provide additional information as an attachment to this form (see next page for specific lab and/or diagnostic information that should accompany the referral)

**URGENT (2 WEEKS)**

- Palpable rectal or abdominal mass suspicious for cancer
- Lower abdominal imaging suspicious for cancer
- Upper abdominal imaging suspicious for cancer

**SEMI-URGENT (4 WEEKS)**

- Unexplained persistent rectal bleeding  
(semi urgent if symptoms have not been investigated recently with weight loss, changes in bowel habits, or family history of colorectal cancer)
- Unexplained iron deficiency anemia
- Bloody diarrhea/features suggestive of IBD
- Severe/progressive odynophagia/dysphagia
- FOBT positive (Not a single office-based FOBT from DRE) (Do NOT test if active bleeding)  
(Include all supporting labs; CBC, iron studies (ferritin +/- iron and TIBC)

**ELECTIVE** (Attach Clinical Notes)

- Above Average Risk screening for colorectal cancer (as per colorectal screening guidelines page 3)
  - Level 1
  - Level 2a
  - Level 2b
- Surveillance for prior colorectal cancer
- Surveillance for prior polyps: include information related to histology, history, size, number and date of previous scope(s)
- Chronic or non-progressive dysphagia  Unexplained significant weight loss
- Barrett's, known history/establish Barrett's  Confirmation of suspected celiac disease
- Persistent or recurrent vomiting or nausea  Screen/manage varices
- Persistent or recurrent diarrhea  Unexplained anemia (not iron deficiency anemia)
- Unexplained rectal bleeding does not meet criteria for Semi-Urgent
- Other:

**NOTE:** For non-specific gastrointestinal symptoms such as abdominal pain, change in bowel habits, dyspepsia, uncontrolled reflux, average risk of colorectal cancer, or management of inflammatory bowel disease, send a consult to Gastroenterology or General Surgery as appropriate for evaluation before endoscopy.

**Additional Information:**

**Scope Required (Endoscopists only)**

Gastroscopy     Colonoscopy     Colonoscopy/Gastroscopy     Flexible Sigmoidoscopy     ERCP     EUS     Other: \_\_\_\_\_

Urgent (2 weeks)     Semi urgent (4 weeks)     Elective (next available)     Time sensitive, specify: \_\_\_\_\_



## WRHA Referral Form for Endoscopy

(Gastroscopy, Colonoscopy, Flexible Sigmoidoscopy)

### INSTRUCTIONS FOR COMPLETION

**Fax completed form and attachments to Endoscopy Central Intake at 204-940-2030**

**All pertinent information must be completed to facilitate proper assessment of the consult.**

**An incomplete consult may be returned to the originating office and, as a result, will be considered as not received.**

**NOTE: This form is for non-emergent consults only. Patients deemed to require immediate attention by their family and/or referring physician should be directed to the emergency room of an appropriate healthcare facility.**

For more information about the referral process go to <http://www.wrha.mb.ca/prog/endoscopy/Central-Intake.php>

#### Suitable for Direct to Scope:

1. Definite indication for endoscopy
2. Presumed able to follow pre procedure instructions and bowel prep when applicable
3. Patient cognitively intact and agreeable to procedure
4. Absence of major medical illness requiring assessment (ASA Class 1, 2 and 3)
5. Not on anticoagulation (excluding Acetylsalicylic Acid or Clopidogrel) or requiring bridging anticoagulation protocol

It is the opinion of the referring physician that an endoscopic procedure is strongly indicated. Key patient data has been provided in the consult. The procedure, alternatives, risks and anticipated outcome has been disclosed. Any further assessment/information required can be obtained at the time of the endoscopic procedure.

#### ASA (American Society of Anesthesia) Classification

**Class 1:** Healthy patient, no medical problems

**Class 2:** Mild systemic disease

**Class 3:** Severe systemic disease, but not incapacitating

**Class 4:** Severe systemic disease that is a constant threat to life

**Class 5:** Moribund, not expected to live 24 hours irrespective of operation

#### Screen for Colorectal Cancer – Determine Above Average Risk:

**Level 1:** One first degree relative less than or equal to 60 with colorectal cancer

**Level 2a:** One first degree relative greater than age 60 with colorectal cancer or advanced adenoma

**Level 2b:** Two first degree relatives with colorectal cancer or advanced adenoma at any age

#### Include the following information for all referrals:

1. CBC, Creatinine, INR
2. For suspected celiac disease: Include TTG and EMA antibodies
3. For unexplained anemia: CBC, liver enzymes, liver function tests, Vitamin B12 levels, celiac serology, ferritin
4. High likelihood of cancer: All recent diagnostic imaging reports (CT, MRI, Ultrasound)
5. Prior endoscopy within last 10 years: ALL endoscopy reports, and pathology reports related to endoscopy.  
If old reports are not available, indicate prior endoscopic provider and approximate dates of procedures.

#### Additional Information:

##### LEGEND

ASA - American Society of Anesthesia

BMI - Body Mass Index

C. difficile - Clostridium difficile

CHF - Congestive Heart Failure

COPD - Chronic Obstructive Pulmonary Disease

DRE - Digital Rectal Examination

ERCP - Endoscopic Retrograde Cholangiopancreatography

ESBL - Extended Spectrum Beta Lactamase

EUS - Endoscopic Ultrasound

FOBT - Fecal Occult Blood Test

IBD - Inflammatory Bowel Disease

IHD - Ischaemic Heart Disease

MI - Myocardial Infarction

MRSA - Methicillin-resistant Staphylococcus Aureus

NSAIDS - Nonsteroidal Anti-inflammatory Drugs

PE/DVT - Pulmonary Embolism/Deep Vein Thrombosis

VRE - Vancomycin-resistant Enterococcus