THE **IBD CENTRE** OF BC

REFERRAL FORM

Fax Completed Form to: 604-416-3249

Date of referral: ________________

Patient Information	**Referring Provider**
First and Last Name:	Provider Name:
Full Address:	MSP #:
PHN:	Clinic Name:
Date of Birth:	Clinic Address:
Gender:	Clinic Phone:
Home Phone:	Clinic Fax:
Cell Phone:	Referral Desk #:
Other Phone:	

Next Available

- ☐ Refer to the next available specialist
- ☐ Prefers to see: ________________

(1st choice of specialist not guaranteed)

Prior Visit to a Gastroenterologist?

- ☐ Yes
- ☐ No

Language & Alerts

- ☐ English
- ☐ Other Languages: ________________
- ☐ VRE Positive

Reason for Referral

Category A

- ☐ High likelihood of Cancer based on imaging or physical exam
- ☐ Active Inflammatory Bowel Disease (IBD) – new dx or flare-up
- ☐ Progressive dysphagia or odynophagia

Category B

- ☐ Rectal bleeding
- ☐ Iron deficiency anemia
- ☐ Celiac disease
- ☐ Positive FIT
- ☐ Stable dysphagia
- ☐ Severe GERD/dyspepsia
- ☐ Severe abdominal pain
- ☐ New change in bowel habits
- ☐ Viral hepatitis

Category C

- ☐ Inflammatory Bowel Disease (IBD) stable
- ☐ Irritable Bowel Syndrome (IBS)
- ☐ Chronic GERD/dyspepsia
- ☐ Chronic constipation/diarrhea
- ☐ Chronic abdominal pain
- ☐ Pancreatitis
- ☐ Surveillance of prior adenomas/colon cancer
- ☐ Screening for cancer
- ☐ Screening for Barrett's esophagus
- ☐ Abnormal liver enzymes/cirrhosis
- ☐ Other liver disease
- ☐ Other

Additional Information / Special Instructions

Please attach the following

- ☐ Past medical history
- ☐ Current medications
- ☐ Procedure and pathology reports
- ☐ Bloodwork, microbiology, diagnostic imaging, consultant letter(s)