



ENDOSCOPY REFERRAL FORM

(Patient ID Label)

Please complete both sides of this request form and forward to Booking Office:

- Hay River fax: 874-7104
- Yellowknife fax: 765-4010
- Inuvik fax: 777-8036

If the referral has not been completed appropriately, it will be returned for completion.

Your request will be prioritized by one of the endoscopists using the information you have provided on this referral form.

Name: _____ **DOB:** _____ **HC#:** _____

Community: _____ **Phone (H):** _____ **(W):** _____

Contact information if patient is staying in Yellowknife from out of town: _____

Translator needed: Yes (language: _____) No

Procedure Requested: Gastroscopy Colonoscopy Bronchoscopy

Medication Allergies: NKDA Eggs or Soya Latex

Please attach list or list here: _____

Medical Conditions:

- Yes No Abnormal coagulation
- Yes No Renal impairment
- Yes No Cardiac disease
- Yes No Diabetes
- Yes No Known alcohol/drug abuse
- Yes No Infection
- Yes No Immunocompromised
- Yes No Prior abdominal, gastric, or bowel surgery
- Yes No Morbidly obese (BMI greater than 40):

BMI _____ Weight _____

Current Medication:

Please attach a current list of medications.

- Yes No Non-steroidal anti-inflammatories
- Yes No ASA
- Yes No Anticoagulant therapy
- Yes No Plavix

Prior endoscopy done by: Internal Medicine General Surgery Other: _____ Date: _____

Please attach the following results with this request:

- CBC and differential
- Creatinine within the past year (if for a colonoscopy)
- FIT results (if a screening colonoscopy is requested and patient is an average risk for CRC; *See current GNWT CRC guidelines)
- Other lab reports where applicable (i.e. stool for ova and parasites)
- Diagnostic Imaging reports pertinent to the referral (i.e. CXR and/or CT scan for Bronchoscopy)
- Related operative reports
- Related pathology reports



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Clinical Details

Indications:	✓	Duration/Details:
Dysphagia		
Barrett's esophagus		
Unexplained weight loss		# of kg: Time frame: _____ Height: _____ Weight: _____
Vomiting		
Hematemesis		Hgb: _____
Jaundice		
Altered bowel habit		
Bright red blood per rectum		
Diarrhea		Number of bowel movement/day: _____ Cultures: _____ Consistency: _____ Duration: _____
Iron deficiency anemia		Date: _____ Hgb: _____ MCV: _____ Iron studies: _____
Melena stool		
Positive Fecal (FIT) Immunochemical test		Date: _____ Number of positive out of 3 samples: _____
Abnormal Diagnostic Imaging (attach results)		
Post colorectal cancer – routine follow up (if not currently on a call-back list)		Initial diagnosis: _____ Surgery: _____ Last colonoscopy done: _____
*Family history of colorectal cancer (indicate which relatives and age)		*See current GNWT guidelines for Colorectal Cancer screening
*Inflammatory bowel disease		*See current GNWT guidelines for Colorectal Cancer screening Duration of disease: _____ Date of last colonoscopy: _____
Other:		

Have you discussed this case with one of the endoscopists? _____

Requested by: _____ / _____ Clinic/Health Centre: _____