OUTPATIENT GI CONSULTATION
REQUEST FORM
Division of Gastroenterology
University of Alberta Hospital
130 Zeidler-Ledcor Centre
86 Avenue & 112 Street, Edmonton, AB T6G 2X8

FAX TO: 780-492-9271   # of Pages ______

PCN CONTACT: ___________________________, Specialist Referral Coordinator FAX: ( ) ______

REFERRAL DATE: ______

PATIENT DEMOGRAPHICS *REQUIRED FIELDS

PATIENT LAST NAME*    FIRST*    INITIALS

DOB: DAY*    MONTH*    YEAR*    PHN/ULI*

PHONE: HOME*    WORK/CELL    OTHER

MAILING ADDRESS*    PC*

REFERRING PHYSICIAN NAME: ___________________________    PRAC ID: __________________

PHONE: ( ) _______________ FAX: ( ) __________________

• Please indicate whether this patient may be triaged to the first available consultant in the Division of Gastroenterology should your specific choice of physician not be available? ☐ Yes    ☐ No*

• If No*, please CHECK the name of the physician whom you like your patient to see:

☐ L. Dieleman    ☐ R. Fedorak    ☐ B. Halloran    ☐ D. Kao    ☐ A. Lazarescu    ☐ P. D'Souza
☐ K. Wong    ☐ JE. Nilsson
☐ G. Sandha    ☐ K. Kroeker    ☐ R. Sultanian    ☐ V. Huang    ☐ S. van Zanten
☐ S. Zepeda-Gomez    ☐ F. Peerani

PREVIOUS TREATMENT
1. Has the patient previously seen other specialists for GI complaints or had an endoscopy in the last 5 years? ☐ Yes    ☐ No

2. Has the patient been treated by a gastroenterologist at the UAH in the last 5 years? ☐ Yes    ☐ No

a. If yes, by whom: Dr. ___________________________

b. Please provide documentation.

3. As patients are often referred for endoscopic procedures, such as colonoscopy, it is very important that information is provided whether the patient is taking:

☐ Warfarin – May Coumadin/warfarin be stopped 5-7 days prior to procedure? ☐ Yes    ☐ No

☐ Pradaxa/dabagatran – May this drug be stopped 3 days prior to procedure? ☐ Yes    ☐ No

☐ Aspirin

☐ Clopidogrel (Plavix) – May Clopidogrel/plavix be stopped 5-7 days prior to procedure? ☐ Yes    ☐ No

4. Medication list appended? ☐ Yes    ☐ No

PREVIOUS DIAGNOSES: Does the patient have documented: ☐ GERD or peptic ulcer disease    ☐ IBD (Crohn’s, ulcerative colitis)    ☐ Liver disease,    ☐ Colon polyps,    ☐ Carcinoma? Please provide documentation if available.

CLINICAL REASON FOR REFERRAL: ___________________________

APPEND ADDITIONAL DETAILS AS NEEDED

Last Rev 26Jan2012
CLINICAL REASON FOR REFERRAL CONTINUED: