Campbell River Direct to Endoscopy Program

(CRDTE) FAX Number 250-286-7115

A. PATIENT INFORMATION		
Last name		
First name		
Date of birth Day Month Year		
PHN		
Primary contact number		
Special instructions		
Email (optional)		
Street address		
City	Prov BC	Postal code
Translator required ☐Yes ☐No If yes, patients first language		

B. SEND RESULTS TO	
Referring Physician	
MSP#	☐ This is the Primary Care provider
Clinic name Street Address Phone Fax	STAMP HERE
Family Physician (if different from referring physician)	
Copy to (Full name)	

C. Procedure(s) Requested (indicate All that apply)

☐ Gastroscopy ☐ Colonoscopy ☐ Flexible sigmoidoscopy +/- Banding

D. Preferred Endoscopist

Requested Endoscopist: ☐ Next Available ☐ Specified_____

E. Reason For Referral (required results listed in bold)

Urgent 8 Weeks	Non Urgent 26 Weeks
☐Iron deficiency anemia(CBC, Ferritin, anti-tTG, IgA)	☐Dysphagia-stable/slow progression
☐Radiologic suspicion of CA (radiology report)	☐Barrett's (include most recent gastroscopy/pathology)
☐Blood mixed WITHIN stool	☐Chronic GERD (>5y, no prior gastroscopy)
	☐Prior colon CA (include pathology and colonoscopy note)
Semi Urgent 12 Weeks	☐Family hx colon CA (1^0 relative <60yr, or two 1^0) not meeting CSP criteria
☐Celiac confirmation (anti-tTG and IgA)	☐Prior polyps not meeting CSP criteria (include pathology and colonoscopy note
☐Diarrhea >6 weeks (anti-tTg, GPMP)	☐+Fit not meeting CSP criteria (FIT results)
☐Constipation >6 weeks	
☐outlet bleeding (blood on tissue or in toilet)	Inflammatory Bowel Disease
	☐Inflammatory bowel disease requiring surveillance (include GI report if available

F. Prior Endoscopies

☐ Yes ☐ No If yes, was previous endoscopy done in VIHA ☐ Yes ☐ 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.

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).
   - 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.
   - 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.

Clinic to acknowledge receipt of referral by faxing ☐Acceptance letter or ☐Incomplete/returned letter

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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	☐Yes	☐No	Drug and indication:
Diabetic (oral/insulin)	☐Yes	☐No	Drug and indication:
Iron	☐Yes	☐No	Drug and indication:
Blood Pressure	☐Yes	☐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	☐Yes	☐No	If yes, include details
Pacemaker/defibrillator	☐Yes	☐No	If yes, include details
Mechanical Heart Valve/stent(s)	☐Yes	☐No	If yes, include details
Previous MI	☐Yes	☐No	If yes, include details
Congestive heart Failure	☐Yes	☐No	If yes, include details
Sleep apnea	☐Yes	☐No	CPAP ☐Yes ☐No
COPD	☐Yes	☐No	If yes, include Severity ☐Mild ☐Moderate ☐Severe Home Oxygen ☐Yes ☐No
Renal impairment (eGFR <30)	☐Yes	☐No	If yes, include recent eGFR
Diabetes Type I Type II	☐Yes	☐No	If yes, include details
Cirrhosis	☐Yes	☐No	If yes, include details

Other Chronic Medical Condition not listed above:

Surgical History (include dates):

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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	Comments
☐ Accepted ☐ Rejected	☐ yes	☐ Surgeon ☐ Triage Nurse ☐ Clerical	For assessment ☐ Surgeon office _____ ☐ Triage Nurse ☐ CSP office	
Date:	Date:	Date:	Date:	Date:

Clinic to acknowledge receipt of referral by faxing ☐Acceptance letter or ☐Incomplete/returned letter