CALGARY ZONE Gastroenterology REFERRAL QUICK REFERENCE

MANDATORY REQUIREMENTS FOR ALL REFERRALS

PATIENT DEMOGRAPHICS

- Patient last name, first name, given names
- PHN/ULI
- Gender
- Address, including city, postal code, province
- Home phone, other phone
- Emergency contact and/or guardian name & phone, and relation to patient

REFERRING PROVIDER

- Name
- Address, *including* city & postal code
- Phone & fax

FAMILY PHYSICIAN

- Name
- Indicate if same as referrer or if patient has no primary care provider
- Phone

OTHER INFORMATION

- Relevant medical history
- Indicate if interpreter is required and language
- Physical limitations
- Economic and social / psychological factors

CO-MORBIDITIES

PLEASE IN THE REFERRAL IF THE PATIENT HAS ANY OF THE FOLLOWING:

- History of stroke
- Cardiovascular disease (*e.g. prior MI*)
- Respiratory disease
- Peripheral vascular disease
- GI disease (*e.g.Crohn's*)
- Renal disease
- Liver disease (*hepatitis B or C*)
- Diabetes
- Rheumatologic disease (*e.g. SLE, scleroderma etc*)
- Active infections (*e.g. MRSA, shingles, TB, VRE*)
- HIV
- Cognitive issues
- Any other concurrent medical problem
- Sleep apnea with CPAP
- Current medication list including antithrombotics (*type and reason*), antiplatlets and insulin / oral hypoglycemic agent

EMERGENCY

for all emergencies, refer directly to the emergency department

OR

CONTACT RAAPID

North: **1-800-282-9111** or **780-735-0811**
South: **1-800-661-1700** or **403-944-4486**

REFERRAL PROCESS

All referrals to a gastroenterologist should be made through Central Access & Triage service, except in the case of the specialists at the Rockyview for whom existing contact details should be used, and for the PLC and FMC physicians listed whose offices should be contacted directly.

GI CENTRAL ACCESS & TRAIGE	**PH** 403-944-6535	**FX** 403-944-6540
DR PRICE	**PH** 403-283-6613	**FX** 403-270-7722
DR MA	**PH** 403-568-9789	**FX** 403-590-8616
DR BASS	**PH** 403-270-9555	**FX** 403-270-7479

As physicians, the health and care of our patients is paramount and it is clear to us that referral processes impact both patient care and outcome. In order to optimally prioritize referrals according to clinical need, consistent and complete information is essential. It is recognized that Alberta is facing significant challenges in access to gastroenterology and hepatology. This document is not meant to address the access problem to GI in Alberta as wait times and access will vary depending on local circumstances. However, hopefully by providing the best possible information about a particular referral the request for consultation can be triaged according to acuity.

We believe the use of a uniform provincial GI referral pathway will improve the referral process and contribute to better patient care. We also expect it has the potential to improve satisfaction with the system, by both physicians, support staff and patients. We recognize that there is considerable variation in the scope, location and practice pattern across the province. The pathway by no means aims to dictate practice, rather to provide a foundation to improve the referral process.

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COLORECTAL CANCER SCREENING

REASON FOR REFERRAL	MANDATORY INFORMATION	ESSENTIAL INVESTIGATIONS & SUGGESTED TIME FRAMES
AVERAGE RISK SCREENING FOR COLORECTAL CANCER *no personal or family history of colorectal cancer or colonic adenomas*	• asymptomatic men and women aged 50-74 • Asymptomatic men and women aged 75-84 screening with FIT may be acceptable provided general health and life expectancy have been assessed. • symptomatic patients indicating possible gastrointestinal (GI) pathology (*e.g., anemia or rectal bleeding*) should be investigated and referred for gastroenterology consultation	**PROCESS: REFER FOR FECAL IMMUNOCHEMICAL TEST (FIT)** • Screen with FIT every 1-2 years starting at 50 years. If FIT is positive or if family history changes, refer for a colonoscopy. • FIT should not be performed within 10 years of a high quality colonoscopy that did not detect polyps in an average risk individual. If the patient is experiencing new gastrointestinal symptoms at any time since the previous colonoscopy, the patient should be referred to a gastroenterologist for a diagnostic follow-up.
FIT : POSITIVE FINDING	• append copy of FIT results	**PROCESS: REFER FOR COLONOSCOPY** • Refer promptly to local colorectal cancer screening program or endoscopist for colonoscopy
PERSONAL HISTORY *of colorectal cancer or colonic adenomas*	• append copy of previous colonoscopy and pathology reports	**PROCESS: REFER FOR COLONOSCOPY** • Referral for follow-up colonoscopy should be consistent with recommendations by local colorectal cancer screening program or endoscopist • FIT not required
POLYP *on sigmoidoscopy, or* **SUSPECTED POLYP** *on ct colonography or other diagnostic*	• sigmoidoscopy report or imaging results (*if available*)	**PROCESS: REFER FOR COLONOSCOPY** • referral to local colorectal cancer screening program or endoscopist for colonoscopy • FIT not required
FAMILY HISTORY OF COLORECTAL CANCER OR †HIGH RISK ADENOMATOUS POLYP(S) • one 1st degree relative diagnosed at 60 years or younger • two or more affected relatives diagnosed at any age *1) High risk adenomatous polyps include: 3-10 adenomas, one adenoma ≥10mm, any adenoma with villous features or high grade dysplasia* *2) Patients with one 2nd or one 3rd degree relative with CRC or a high risk adenomatous polyp are considered an average risk.*	• Age 74 or younger. Patients over age limit may be reviewed on a case by case basis. • The patient must be clinically stable and able to undergo procedural sedation. • Significant comorbidities may affect eligibility for a screening colonoscopy in some settings. • Copy of previous colonoscopy and pathology report (*if applicable*) • Symptomatic patients indicating possible gastrointestinal (GI) pathology (*e.g., anemia or rectal bleeding*) should be investigated and referred for gastroenterology consultation. **OPTIONAL** • CBC, electrolytes, creatinine	**PROCESS: REFER FOR COLONOSCOPY** • Screening begins at age 40 or 10 years earlier than the youngest diagnosis in the family, whichever comes first. • referral to local colorectal cancer screening program or endoscopist for colonoscopy • FIT not required **IF PATIENT HAS 1ST DEGREE RELATIVE AFFECTED WHO WAS OLDER THAN 60 WHEN DIAGNOSED** • refer for FECAL IMMUNOCHEMICAL TEST (FIT) • screen with FIT every 1-2 years starting at age 40. • if FIT is positive or if family history changes, refer for a colonoscopy

CALGARY ZONE Gastroenterology REFERRAL QUICK REFERENCE

COMMON LUMINAL DISORDERS

REASON FOR REFERRAL	MANDATORY INFORMATION	ESSENTIAL INVESTIGATIONS & SUGGESTED TIME FRAMES	
GI BLEED • Hematemesis • Melena (*define*) • Low hemoglobin • Hematochezia	• Duration • Frequency	**1 MONTH** • CBC/ hemoglobin level • Creatinine	**IF INDICATED** • INR / PTT
RECTAL BLEED	• Recent change in bowel habit • Duration & frequency • Family history	**1 MONTH** • CBC/ hemoglobin level • CRP (*optional if ulcerative colitis is suspected*)	**IF AVAILABLE** • Previous colonoscopy / flexible sigmoidoscopy or imaging reports
IRON DEFICIENCY ANEMIA	• Any GI symptoms • Family history of GI malignancy (*colorectal cancer, gastric cancer, celiac disease, IBD*) • Duration & progression • Response to iron therapy (*if applicable*)	**6 MONTHS** • Ferritin, TTG, IgA level	
CHANGE IN BOWEL HABIT	• Define what the problem is including duration of symptoms	**1 YEAR** • CBC	
CONSTIPATION	• Define the problem including the frequency of bowel movements and duration of symptoms • Attempted interventions & response to therapy	**6 MONTHS** • CBC, ferritin, TSH, TTG, IgA, glucose, calcium/albumin	
ABNORMAL IMAGING OF GASTROINTESTINAL TRACT	• Why did you request the imaging – include a description of the symptoms	**3 MONTHS** • CBC, electrolytes, creatinine	
GASTROESOPHAGEAL REFLUX DISEASE/ DYSPEPSIA *Non-cardiac chest pain*	• Duration and frequency of symptoms • Severity of symptoms • Whether patient is responding to medication	**1 YEAR** • CBC	**IF AVAILABLE** • imaging report
BARRETT'S ESOPHAGUS	• Duration and diagnosis if present • Duration of symptoms • Use of PPI	**6 MONTHS** • CBC	**IF AVAILABLE** • previous gastroscopy report • previous pathology report
DYSPHAGIA	• Duration, severity • Solids or liquids? • Progressive or intermittent, unchanged? • Weight loss	**8 WEEKS** • CBC (only for ages 50+)	**IF AVAILABLE** • imaging report

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COMMON LUMINAL DISORDERS

REASON FOR REFERRAL	MANDATORY INFORMATION	ESSENTIAL INVESTIGATIONS & SUGGESTED TIME FRAMES
WEIGHT LOSS *unexplained*	• Amount & duration of weight loss including BMI • Associated symptoms • Medications and relevant investigations done to date • Associated medical conditions which might contribute to weight loss (*cancer, COPD etc.*)	**6 MONTHS** • CBC, ferritin, electrolytes, creatinine • Liver enzymes (*ALT, AST, alkaline phosphatase, bilirubin*) • Thyroid function test • Celiac serology/screen, TTG, IgA, albumin
ABDOMINAL PAIN • Acute abdominal pain • Chronic abdominal pain	• Frequency • Severity • Duration	**1 MONTH** • CBC , electrolytes, BUN, creatinine • LFTs – ALT, ALK Phos, GGT and AST (*where available*), bilirubin • Celiac serology/screen, TTG, IgA **OPTIONAL** • CRP, lipase
DIARRHEA	• Frequency, duration • Stool form • BMI • Attempted investigations & response to therapy	**6 MONTHS** • Stool cultures for: C&S, O&P, and C. difficile (*if relevant acute*) • TSH, CBC, CRP • Celiac serology/screen, TTG, IgA
CELIAC DISEASE • Celiac disease • Non celiac gluten sensitivity	• Is patient following a gluten-free diet? • Copy of small biopsy imaging and report • In general it is preferred that small bowel biopsies are done to prove that the patient has celiac disease before a gluten-free diet is started.	**6 MONTHS** • CBC, ferritin, TSH • Celiac serology/screen, TTG, IgA **OPTIONAL** • folate, INR, Ca/albumin, B12 **IF AVAILABLE** • previous gastroscopy & pathology reports
INFLAMMATORY BOWEL DISEASE *ulcerative colitis, Crohn's disease* • Active or suspected IBD • Inactive IBD	• Symptoms » diarrhea (*bloody / non-bloody*) » abdominal pain » vomiting » weight loss (*Kgs / months*) » fever » duration of symptoms » bowel movements per day » extraintestinal (*please list*)	**ACTIVE OR SUSPECTED** **3 MONTHS** • stools for C&S, O&P and C difficile toxin • CBC, electrolytes, creatinine, CRP, iron, ferritin, ALT, AST, Alk phos, GGT, bilirubin, albumin, (*celiac serology if not previously done*) • B12 • relevant endoscopy, diagnostic imaging, surgical/pathology reports **INACTIVE** • all above except stool tests
IRRITABLE BOWEL SYNDROME	• Frequency & duration of symptoms • Severity of symptoms & Impact on daily activities • Previous GI consultations, attempted interventions & response to therapy	**6 MONTHS** • CBC, celiac serology/screen, TTG, IgA, TSH, and if diarrhea: stool for O & P • CRP

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HEPATOLOGY

REASON FOR REFERRAL	MANDATORY INFORMATION	ESSENTIAL INVESTIGATIONS & SUGGESTED TIME FRAMES	
ACUTE LIVER DISEASE / HEPATITIS • ALT &/ AST > 250	• Medication history including herbs / remedies/ all OTC drug use/illicit drugs • Symptoms (*e.g. jaundice, abdominal pain etc*) • DM • Alcohol intake • BMI • Systemic symptoms (*i.e. sore throat, rash*)	**1 MONTH** • Liver enzymes: ALT, AST, Alk phos, GGT, LDH • Liver function: INR, total / direct bilirubin, albumin • CBC, electrolytes, creatinine, CK • ultrasound **3 MONTHS** • Previous liver enzymes if available	• Etiological: Hep A IgM, Hep B surface Ag, Hep B core IgM, Hep C Ab, IgG; IgA, IgM, ANA (*anti-nuclear antibodies*), SMA (*anti-smooth muscle antibody*), ceruloplasmin, ferritin, transferrin saturation, alpha 1 antitrypsin level • Toxin screen (*acetaminophen, cocaine, if applicable)*
CHRONIC LIVER DISEASE / ELEVATED LIVER ENZYMES	• Medication History including herbs / remedies / all OTC drug use • Symptoms (*e.g. jaundice, abdominal pain, confusion, pruritus, pedal edema, ascites, GI bleeding*) • Comorbidities (*e.g. DM, cholesterol, CAD etc*), thyroid disease • Alcohol intake • BMI	**3 MONTHS** • Liver enzymes: ALT, AST, Alk phos, GGT, LDH • Liver function: INR, total / direct bilirubin, albumin • CBC, electrolytes, creatinine, CK • Fasting lipids and A1c if applicable **6 MONTHS** • Old liver enzymes	• Etiological: Hep B, C serology, IgG,IgA, IgM, ANA (*anti-nuclear antibodies*), SMA (*anti-smooth muscle antibody*), AMA (*anti-mitochondrial antibodies*), ceruloplasmin, copper, ferritin, transferrin saturation, alpha 1 antisrypsin level, ATTG (*anti-transglutaminase antibodies*) • Abdominal ultrasound (with hepatic / portal vein doppler where available
CIRRHOSIS OF LIVER • Decompensated jaundice, encephalopathy, ascites or varices • Compensated	• Etiology- when / if established. • How was diagnosis established? • Symptoms of decompensation (*i.e. jaundice, encephalopathy*) • Alcohol use	**3 MONTHS** • Liver enzymes: ALT, AST, Alk phos, GGT • Liver function: INR, total / direct bilirubin, albumin • CBC, electrolytes, creatinine, AFP • Fibroscan results (*if available*) **6 MONTHS** • Abdominal ultrasound (*with hepatic / portal vein doppler where available*) • CT / MRI or US if available	**1 YEAR** *(If not previously done)* • Etiological: Hep B, C serology, IgG, IgA, IgM, ANA (*anti-nuclear antibodies*), SMA (*anti-smooth muscle antibody*), ANA (*anti-smooth muscle antibody),* AMA (*anti- mitochondrial antibodies*), ceruloplasmin, copper, ferritin, transferrin saturation, alpha 1 antitrypsin level, ATTG (*anti transglutaminase antibodies*) **IF AVAILABLE** • Liver biopsy / endoscopy results
ISOLATED LIVER MASS	• Weight and BMI • Hx of liver disease / cirrhosis • Metastatic cancer to liver excluded (*i.e. no colon cancer, breast cancer, etc.*)	**1 MONTH** • CBC, electrolytes, BUN, ferritin, creatinine • Liver enzymes: ALT, AST, Alk Phos, GGT, LDH • Liver Function: INR, bilirubin total/direct, albumin **3 MONTHS** • Alpha fetoprotein	**IF NOT PREVIOUSLY DONE** • Etiological: Hep B, C serology, AMA, IgG,IgA, IgM, ANA, Anti-smooth muscle antibody, ceruloplasmin, copper, ferritin, transferrin saturation, alpha 1 antitrypsin level • CT / MRI or US if available

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PANCREATOBILIARY

REASON FOR REFERRAL	MANDATORY INFORMATION	ESSENTIAL INVESTIGATIONS & SUGGESTED TIME FRAMES
PANCREATITIS / PANCREAS ABNORMALITIES • Acute pancreatitis • Disorder of pancreas • Disorder of biliary tract • Primary sclerosing cholangitis	• Hospitalization details – discharge summary and relevant information • Alcohol and gallstones are common causes of pancreatitis - history of both to be included in medical history • To include all relevant imaging (*copy of report and findings for all*)	**2 MONTHS** • ALT, AST , alkaline phosphatase, GGT, bilirubin, lipase, liver enzymes • Creatinine • BUN • Electrolytes, CBC, Lipid profile, Ca
REFERRAL FOR ERCP	• Medical history • Current medication • To include all relevant imaging (*copy of report and findings for all*)	**1 MONTH** • CBC, INR, PTT • Surgical history - cystectomy, gall bladder removal **3 MONTHS** • ALT, ALP, GGT, bilirubin, lipase, creatinine **IF APPLICABLE** • pregnancy test
REFERRAL FOR ENDOSCOPIC ULTRASOUND *examination of pancreas bile duct colon esophagus, other*	• Medical history • Current medication • To include all relevant imaging (*copy of report and findings*)	**3 MONTHS** • ALT, ALP, GGT, bilirubin, lipase • CBC, PTT/INR • Surgical history
REFERRAL FOR CAPSULE ENDOSCOPY • Gastrointestinal hemorrhage	• Indication / question to be answered • Relevant medications e.g. NSAIDs, iron *Not usually a family physician direct referral (either directly referred or recommended by a gastroenterologist / internal medicine or a surgeon that has seen and scoped the patient)*	**8 WEEKS** • CBC, creatinine, ferritin • Iron studies • BUN (*if patient actively bleeding*) • CT scan or small bowel follow if available

OTHER

OTHER	• please specify and attach relevant investigations	• n/a