Alberta Health Services

Division of Gastroenterology
Inflammatory Bowel Disease Consultation and Research Unit
CONSULTATION REQUEST FORM

IBD CLINIC UNIVERSITY OF ALBERTA

Fax Completed Form to: 780-492-9271

The form is designed to expedite your request for consultation of patients with known, or suspected, Inflammatory Bowel Disease. Referrals may be directed to individual physicians, however, patients may be triaged to the soonest available appointment should they require more urgent attention. Should you choose to refer your patient via letter please include all the information indicated on this form in your letter. Date of Referral:_____

REFERRING PHYSICIAN

NAME:_____ PRAC ID: _____

PHONE: ( )_____ FAX: ( ) _____

PATIENT DEMOGRAPHIC INFORMATION

Patient's Full Name:

(Last)
_____

_____ _____
(First) (Middle name or initial)

ULI/PHN Number: _____

Date of Birth (DD/MON/YEAR)_____

Gender: Male / Female (please circle)

Patient's Mailing Address:

_____
(Apt/Suite#) (Street Address)
_____

_____ _____ _____
(City) (Province) (Postal Code)

Home Phone:_____

Work Phone:_____

Cell Phone:_____

Email Address:_____

□ Suspected IBD

□Family History (list details:_____
_____
_____

- Please attach most recent consultation, imaging, laboratory, and complete the symptoms section below
- Current and previous medications: (Please attach a current list)

□ Known history of IBD

□ Crohn's Disease □ Ulcerative Colitis

□ Has previously seen another Gastroenterologist (please include Doctor's name) _____

- Please attach most recent consultation, endoscopy, diagnostic imaging, pathology reports, and all previous surgical reports
- Current and previous medications: (Please attach a current list)

•Is this patient in an active flare?
□**Yes (If yes, complete symptom section below)** □**No**

IBD Symptoms:

□ Diarrhea
- □ Bloody
- □ Non-bloody

□ Fever

□ Bowel Movements Per Day_____

□ Abdominal Pain

□ Weight Loss (_____kgs over____mo)

□ Duration of Symptoms_____

□ Extraintestinal (please attach a list)

□ Other_____
_____
_____

IBD Laboratory Test (Please have all the following investigations completed and results sent with this referral form)

☐ CBC ☐ CRP ☐ Microbiology (Stools for C&S, O&P, and C. Difficile Toxin) ☐ Fecal Calprotectin

(see instructions on the back of the requisition)

Do you have a specific preference for the physician asked to see your patient?

Yes [ ] Name:_____** see box → No [ ]

If your specific choice of physician is not immediately available, **urgent referrals will be directed to the first available consultant in the GI Division to ensure a timely evaluation of your patient **

UAH use only: Reviewing doctor's initials_____ date (d/m/y)_____

Triaged category *(circle)* emergent urgent semi-urgent non urgent more info needed

Patient disposition: _____

Notifications — Referring Dr [ ] Patient [ ] Other [ ] _____

Processing clerk's initials_____date (d/m/y)_____