Alberta Health Services

CAPSULE ENDOSCOPY REFERRAL FORM

South Health Campus, GI/Hepatology Clinic
4448 Front St. SE, Calgary, AB T3M 1M4
Tel: (403) 956-3804 Fax: (403) 956-3838

PATIENT LABEL
NAME
DOB
PHN
RHRN
PHONE

REFERRING PHYSICIAN
NAME
ADDRESS
PHONE
FAX

FAMILY PHYSICIAN

PATIENT LOCATION ☐ **OUTPATIENT** ☐ **INPATIENT** **LOCATION** _____ **EXPECTED DATE OF D/C** _____
PRIMARY GI _____

INDICATION

☐ OBSCURE GI BLEEDING

☐ OVERT GI BLEEDING
DATE OF LAST EPISODE _____
☐ PRBC TRANSFUSED ON _____

☐ OCCULT GI BLEEDING/IRON DEFICIENCY ANEMIA
☐ UBT/GASTRIC BX NEGATIVE
☐ CELIAC SEROLOGY/DUODENAL BX NEGATIVE
☐ EGD/COLONOSCOPY WITHIN 2 YEARS
☐ IRON SUPPLEMENTATION ☐ ORAL ☐ IV

☐ CROHN'S DISEASE

☐ SUSPECTED CROHN'S DISEASE
☐ SYMPTOMS _____
☐ OBJECTIVE FINDINGS _____
☐ SB C/S IMAGING _____

☐ CROHN'S DISEASE/IBD
☐ ASSESS FOR SMALL BOWEL INVOLVEMENT
☐ ASSESS FOR EFFECTIVENESS OF TX

☐ REFRACTORY CELIAC DISEASE

☐ tTG NEGATIVE
☐ EGD < 6 MONTHS NEGATIVE
☐ SYMPTOMS _____

☐ POLYPOSIS

☐ FAP ☐ HAMARTOMATOUS POLYPOSIS ☐ OTHER

☐ ABNORMAL SMALL BOWEL IMAGING

☐ OTHER

SPECIAL CONSIDERATIONS (CHECK ALL THAT APPLY)

☐ IMPLANTABLE CARDIAC DEVICE ☐ DYSPHAGIA ☐ ZENKER'S DIVERTICULUM ☐ ESOPHAGEAL STRICTURE
☐ PREGNANCY ☐ KNOWN GASTOPARESIS ☐ IMPAIRED SWALLOWING (i.e. PEDIATRIC)
☐ OTHER _____

INCREASED RISK FOR CAPSULE RETENTION (CONSIDER PATENCY CAPSULE TEST)

☐ PRIOR SBO ☐ STRICTURES ☐ ABNORMAL SB IMAGING ☐ LONG-TERM HIGH-DOSE NSAIDS ☐ ADHESIONS
☐ SUGGESTIVE SYMPTOMS _____

ADDITIONAL INFORMATION

FAX COMPLETED FORM TO (403) 956-3838

INCOMPLETE REFERRALS MAY RESULT IN DELAY PROCESSING

PLEASE INCLUDE: BLOODWORK, REPORTS FOR ENDOSCOPY, PATH & DI, CONSULT & D/C SUMMARIES IF NOT AVAILABLE IN NETCARE

REFERRALS ARE ACCEPTED BY GASTROENTEROLOGY ONLY
REFERRALS ARE ASSESSED FOR APPROPRIATENESS AND TRIAGED ACCORDING TO URGENCY
REFERRING PHYSICIAN REMAINS RESPONSIBLE FOR CASE MANAGEMENT AFTER CAPSULE ENDOSCOPY
PATIENT WILL BE CONTACTED BY CAPSULE ENDOSCOPY OFFICE WITH APPOINTMENT IF APPROVED