McMaster Children's Hospital

PLACE PATIENT
INFORMATION LABEL HERE

# PEDIATRIC GASTROENTEROLOGY HEPATOLOGY and NUTRITION REFERRAL REQUEST

**REFERRING PROVIDER (NAME/FAX/SPECIALTY):**

**REASON FOR REFERRAL:**

**RELEVANT HISTORY:**

**CURRENT MEDICATIONS:**

**TEST RESULTS (PLEASE ATTACH OR WRITE BELOW):**

CRP:
CBC:
ALBUMIN:
CELIAC SCREEN:
TOTAL IMMUNOGLOBULINS:

OTHER:

**ALARM FEATURES:**

- ☐ Bloody diarrhea
- ☐ Anemia
- ☐ Intractable vomiting
- ☐ Dysphagia
- ☐ Jaundice
- ☐ Elevated liver enzymes
- ☐ Weight loss
- ☐ Failure to thrive
- ☐ Night time stools
- ☐ Elevated CRP
- ☐ Fever
- ☐ Bilious emesis

**DURATION OF SYMPTOMS:**

- ☐ Weeks
- ☐ Months
- ☐ Years

**REQUIRED INFORMATION:**

- ☐ **NEED FOR INTERPRETER? (LANGUAGE: _______________)**
- ☐ **GROWTH CHARTS HAVE BEEN ATTACHED**

**ACCURATE COMPLETION OF THIS FORM WILL HELP TRIAGE YOUR PATIENT MOST EFFICIENTLY
IF CONCERNS FOR AN EMERGENCY or URGENT CONSULT PLEASE REQUEST TO SPEAK DIRECTLY TO PEDIATRIC GI ON-CALL **905 521 5030**

FAX TO 905 521 2627

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