Hamilton Health Sciences

# BARRETT'S ESOPHAGUS REFERRAL

If you have any questions, please contact the Nurse Clinician office at 905-521-2100 ext. 76933

**Date:** (yyyy/mm/dd) _____ **(Please Print)**

Referring Physician _____

Signature _____

Phone: _____ (ext) _____ Fax _____ OHIP Billing Number _____

| | | |
|---|---|---|
| Patient's Last Name | First Name | |
| Address – Street | City | Postal Code |
| Telephone: ( ) | | Ext. |
| Cell Phone: ( ) | | |
| Date of Birth (yyyy/mm/dd) | Age | Gender ☐ M ☐ F |
| HIN | Family Physician | |

**BARRETT'S:** ☐ New Diagnosis **or** ☐ Surveillance

Length of circumference: _____ cm

Maximum length _____ cm

Nodular Barrett's epithelium ☐ No ☐ Yes

Family history of esophagus cancer ☐ No ☐ Yes

Is the patient on PPI? ☐ No ☐ Yes – dose _____ frequency _____

Low grade dysplasia (confirmed by pathology on 2 or more occasions) ☐ No ☐ Yes

High grade dysplasia (confirmed by pathology on 1 or more occasions) ☐ No ☐ Yes

**CLINICAL HISTORY: Does patient have any of the following medical conditions?**

Active alcohol abuse and / or chronic high dose opioid or benzodiazepine utilization? ☐ No ☐ Yes – Comments _____

Coronary Artery Disease with Unstable Angina or a recent MI (within the past 12 months) ☐ No ☐ Yes – Comments _____

Congestive Heart Failure ☐ No ☐ Yes – Comments _____

Pacemaker / ICD ☐ No ☐ Yes – Comments _____

Lung Disease ☐ No ☐ Yes – Comments _____

Sleep Apnea ☐ No ☐ Yes – Comments _____

Malignant Hyperthermia ☐ No ☐ Yes – Comments _____

Anticoagulant Therapy ☐ No ☐ Yes – Comments _____

Diabetes ☐ No ☐ Yes – Comments _____

BMI greater than 40 ☐ No ☐ Yes – Comments _____

Other / Clinical History _____

_____

_____

_____

**Current Allergy List:** ☐ Faxed with this Referral **Current Medication List:** ☐ Faxed with this Referral

**Please fax legibly completed form, endoscopy, pathology and lab reports to 905-526-0594.**

**Confirmation of Appointment Date and Time will be faxed to the Referring Physician once it has been booked**