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:

**** Appointments for possible Celiac Disease will be expedited and patients should* ***remain on gluten***

TOTAL IGA:

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**
- ☐ **THIS REFERRAL IS FROM A FAMILY PHYSICIAN'S OFFICE**

***NEW: Timely consultation is available through eConsult**

**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

UPDATED: April 16 2021