McMaster University — Inspiring Innovation and Discovery

McMaster University Medical Centre — HAMILTON HEALTH SCIENCES

*Please Print Clearly* →

# IBD CLINIC REFERRAL REQUEST

**DATE** (yyyy/mm/dd) _____

**ACUITY** ☐ Routine ☐ URGENT

**REFERRING PHYSICIAN** _____

Phone: _____ ext _____

Fax: _____

| | | |
|---|---|---|
| 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 | |

**PHYSICIAN SIGNATURE** _____ **OHIP Billing Number** _____

**REFERRAL FOR DR:** ☐ Next Available ☐ Smita Halder ☐ John Marshall ☐ Neeraj Narula ☐ Frances Tse

**Reason for Referral:**

_____

_____

_____

_____

_____

**Medical History:**

_____

_____

_____

_____

_____

_____

**Anatomical Disease Distribution**

**Ulcerative Colitis:**

- ☐ proctitis
- ☐ left-sided colitis
- ☐ extensive / pan-colitis

**Surgical History:**

Intestinal resection: ☐ No ☐ Yes

(if yes, describe)

_____

_____

_____

_____

_____

**Crohn's Disease:**

- ☐ gastroduodenal
- ☐ mid small bowel
- ☐ terminal ileum
- ☐ colon
- ☐ perianal

**History of the following complications:**

Fistulization ☐ No ☐ Yes

Abscess ☐ No ☐ Yes

Stricturing ☐ No ☐ Yes

**Current Medications:**

_____

_____

_____

_____

_____

**OR** ☐ Separate list faxed with referral

| **Prior or Current Use Of:** | **No** | **Yes** |
|---|---|---|
| Corticosteroids | ☐ | ☐ |
| Immunosuppressives | ☐ | ☐ |
| Infliximab (Remicade/Inflectra) | ☐ | ☐ |
| Adalimumab (Humira) | ☐ | ☐ |
| Golimumab (Simponi) | ☐ | ☐ |
| Vedolizumab (Entyvio) | ☐ | ☐ |
| Ustekinumab (Stelara) | ☐ | ☐ |

**Most Recent Colonoscopy:**

*(yyyy/mm/dd)* _____

**Date of Most Recent Small Bowel Study:** *(yyyy/mm/dd)*

CT _____

MR _____

***All referrals MUST be complete and submitted with relevant bloodwork, imaging and endoscopy reports.***

**Please indicate the relevant reports being faxed with this referral:** ☐ Bloodwork ☐ Imaging ☐ Endoscopy

**Please fax completed referral and accompanying documentation to 905-526-0594**

**Incomplete referrals <u>WILL NOT BE PROCESSED</u>**

*If you have any questions about the status of your referral, please contact: 2F2 Digestive Diseases Clinic (905) 521-2100 ext 75353*

**Confirmation of Appointment Date and Time will be provided via return fax**

| **FOR 2F CLINIC USE ONLY** | MUMC ID Number _____ | Appointment Date (yyyy/mm/dd) | Appointment Time (hh:mm) |
|---|---|---|---|
| Appointment Confirmation Faxed | Date (yyyy/mm/dd) | Time (hh:mm) | By: (print) _____ (Signature) _____ |