

RAPID ACCESS CLINIC FOR ENDOSCOPY (RACE) REFERRAL

Vernon Jubilee Hospital

Patient Name (last) _____
 (first) _____
 DOB (dd/mmm/yyyy) _____
 PHN _____ MRN _____
 Account/Visit # _____
IH USE ONLY

- Dr. S Ainslie Dr. H Hwang Dr. M Horkoff Dr. Q Parker Dr. K Langer Dr. S Langer Dr. K Wiseman

ON CALL SURGEON MUST BE CALLED FOR ALL REFERRALS 250-545-2211	Please fax completed form to <input type="checkbox"/> 250-545-8212 General Surgery Clinic <input type="checkbox"/> 250-545-2781 Dr. H Hwang
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PATIENT INFORMATION			
Last Name, First Name	PHN	Day Time Phone	Date of Birth

INDICATION FOR GASTROSCOPY	INDICATION FOR COLONOSCOPY	INDICATION FOR GASTROSCOPY AND/OR COLONOSCOPY
<input type="checkbox"/> Dysphagia or odynophagia Any age	<input type="checkbox"/> FIT+ Age <50 or 75–85	<input type="checkbox"/> Chronic GI bleeding Any age
<input type="checkbox"/> GI bleeding Any age	<input type="checkbox"/> Positive barium enema or CT colonography Age 75–85	<input type="checkbox"/> Iron deficient anemia with Hemoglobin < 110 Any age
<input type="checkbox"/> Recurrent vomiting Any age	<input type="checkbox"/> Loose stool and rectal bleeding Age 40 +	<input type="checkbox"/> Unintentional weight loss Any age
<input type="checkbox"/> History of Barrett's with change in symptoms Any age	<input type="checkbox"/> Loose stool without rectal bleeding > 6 wk Age 60 +	<input type="checkbox"/> Suspicious imaging study Any age
<input type="checkbox"/> Abdominal mass Any age	<input type="checkbox"/> Persistent rectal bleeding > 6 wk Age 60 +	<input type="checkbox"/> Other
<input type="checkbox"/> Other Any age	<input type="checkbox"/> Palpable rectal mass Any age	

MEDICAL INFORMATION	
Exclusions for RACE clinic (please call on call surgeon to discuss case): <input type="checkbox"/> Age under 16 <input type="checkbox"/> Anticoagulated (medication): _____ <input type="checkbox"/> On home oxygen <input type="checkbox"/> Unable to tolerate bowel prep <input type="checkbox"/> Severe frailty (could not withstand a general anesthetic) <input type="checkbox"/> Pacemaker or ICD <input type="checkbox"/> Diabetes on insulin <input type="checkbox"/> Valvular heart disease <input type="checkbox"/> Coronary stent placement within last 12 months <input type="checkbox"/> Severe cardio-respiratory disease <input type="checkbox"/> Hemodynamically unstable <input type="checkbox"/> Confirmed Antibiotic Resistant Organism	Medications: Please provide a full list or pharmanet Past medical history (list significant conditions) Allergies Previous surgeries
Please attach relevant lab work, imaging reports and previous endoscopy reports if available	
NB: The objective of the RACE clinic is to expedite endoscopy with direct-to-procedure booking with the first available endoscopist. The attending endoscopist will assume care of the patient for the purposes of follow-up regardless who was originally contacted. If the patient is not deemed appropriate for the RACE clinic, they will be booked for an office appointment	

Permanent part of the health record

Date (dd / mmm / yyyy)	Time (24 hour)	Printed Name	Signature	Initials	Designation / College ID #
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