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Consultation Request

Acute Consultation – **Call SFCC**
SFCC Urban: 1 (866) 766-6050

Outpatient Consultation – **Fax Referral**
GI Peds Fax: (306) 655-3534

Existing Patients – **Call Clinical Coordinator**
GI Clinical Coordinator: (306) 655-6479

Please note the Peds GI service is not an acute emergency service, in the case of an emergency please seek medical attention at the nearest Emergency Department or contact SFCC.

Requirement for all referrals:
Complete the intake sheet in order for the patient to be efficiently triaged. Failure to provide the relevant information will result in the referral being returned. Document anthropometry is required prior to the referral being triaged.

Problem based referral pathways:
A symptom based referral pathway has been developed in order to aid with efficient and appropriate patient triage. Based on the triage criteria and work-up the patient will be assigned to the appropriate provider by the Peds GI intake team. Wait times listed are a guideline only and will vary depending on demand.

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CONSULTATION REQUEST

Date: _____

To: _____ Service: _____

From: _____ Service: _____

Please Check: ☐ Urgent ☐ Routine

Consultation Submitted: Date & Time: _____

Patient Location: _____

Request:

☐ Consultation Only

☐ Consultation Therapy

☐ Transfer to Your Care

Signature: _____

Transfer Accepted: ☐ Yes ☐ No

Date: _____ Consultant Signature: _____

Name: _____

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Reason for Referral	Clinical Symptoms and Signs	Work-up required to referral (attach)	Referral/Triage time frame
Abdominal Pain (Acute)	**Exclude life threatening causes**: ☐Intestinal obstruction, perforation, hemorrhage. **Consider non GI causes:** ☐Gynecological, urologic, musculoskeletal	☐CBC ☐ESR/CRP ☐BUN ☐Lytes ☐Creatinine ☐LFT ☐Lipase ☐Urinalysis, HCG if applicable ☐AXR/Ultrasound as indicated	☐General Pediatrics or Pediatric Surgery referral as indicated
Abdominal Pain (Recurrent or Chronic)	**Red flag signs:** ☐Loss of weight ☐Unexplained fever ☐Persistent vomiting +/- hematemesis ☐Chronic diarrhea ☐Blood in stool ☐Persistent RUQ or RLQ abdominal pain ☐Short stature ☐Delayed puberty ☐Abnormal physical findings Family history of IBD, peptic ulcer disease, pancreatitis and autoimmune disease	☐CBC ☐CRP ☐LFTs ☐Lipase ☐Albumin ☐Iron Studies ☐TTg-IgA/Total IgA ☐Stool Culture/O&P ☐Consider imaging AXR/Ultrasound	☐Red flags/abnormal blood work present, fax referral to Peds GI for outpatient consultation ☐No red flags and normal work up, to be assessed by Pediatrician
Ascending Cholangitis **Biliary Atresia Post Kasai Portoenterostomy**	☐Screen for non GI infection ☐If negative consider Ascending Cholangitis	☐LFT ☐INR/PT ☐CBC ☐Blood Culture ☐Urine Culture ☐Viral swabs if clinically indicated	☐Call SFCC
Celiac Disease	**At risk populations:** ☐T1DM ☐Downs Syndrome ☐Tuners Syndrome ☐Williams Syndrome ☐IgA Deficiency ☐Autoimmune Thyroid Disease ☐Family history of Celiac Disease	☐TTG-IgA on gluten inclusive diet for 1 month ☐IgA ☐CBC ☐Random Glucose ☐TSH ☐LFT ☐DGP-IgA is not useful in children >2	☐Fax referral to Peds GI for Outpatient Consultation (Referral directly to GI Dietitian is inappropriate)

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Chronic Diarrhea (>4weeks)	**Red flag signs:** ☐Loss of weight ☐Unexplained fever ☐Persistent vomiting +/- hematemesis ☐Blood in stool ☐Persistent RUQ or RLQ abdominal pain ☐Short stature ☐Delayed puberty ☐Abnormal physical findings ☐Family history of IBD, peptic ulcer disease, pancreatitis and autoimmune disease ☐Early onset (neonatal) ☐Electrolyte abnormalities	☐CBC ☐CRP ☐LFTs ☐Lipase ☐Albumin ☐Iron Studies ☐BUN ☐Lytes ☐Creatinine ☐TTG-IgA/Total IgA ☐Stool Culture/O&P ☐Fecal Elastase	☐To be assessed by Pediatrician prior to GI clinic referral
Constipation	**Red flag signs:** ☐Fever, nausea, vomiting, weight loss, decreased appetite, bloody diarrhea ☐Onset <1 month ☐Delayed passage of meconium ☐Failure to thrive ☐Abnormal neurologic exam ☐No response to treatment	☐TSH ☐BUN ☐Lytes ☐Creatinine ☐TTG-IgA/Total IgA ☐CK/CK-MB Fraction ☐Sweat Test if indicated	☐Fax referral to Peds GI for outpatient Consultation ☐No red flags and normal work up, to be assessed by Pediatrician.
Dysphagia	**Three phases of deglutition** **Oral Phase:** ☐Drooling ☐Poor suck ☐Refusal to swallow ☐Cough ☐Gagging ☐Choking ☐Respiratory distress and aspiration **Pharyngeal Phase:** ☐Difficulty initiating swallowing **Esophageal Phase:** ☐Dysphagia or odynophagia swallowing	☐Symptoms of oral or pharyngeal pathology refer to SLP or MBS ☐Symptoms suggestive of esophageal pathology do barium swallow.	☐Fax referral to Peds GI for outpatient consultation ☐Start on a Proton Pump Inhibitor prior to referral.

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Emergencies	**The following are emergencies and should be referred for urgent assessment:** ☐Upper GI bleed with hemodynamic instability ☐Abnormal LFT's with INR>2 in a fully conscious child or INR>1.5 in an encephalopathic child	☐Appropriate resuscitation as clinically indicated	☐Fax referral to Peds GI for outpatient consultation
Failure to Thrive	**Screen for causes of malnutrition** ☐Organic disease related ☐Behavioral/psychological ☐Dietary intake and food security	☐CBC ☐CRP ☐LFT ☐Lipase ☐Albumin ☐Iron Studies ☐BUN ☐Lytes ☐Creatinine ☐TTG-IgA/Total IgA ☐Fecal Elastase ☐Sweat Test if indicated	☐Growth chart including correction for gestational age ☐Pediatrician +/- Dietitian referral required prior to GI opinion
Fatty Liver with Transaminitis and BMI >85th centile	**Assess for the following** ☐Metabolic syndrome ☐Autoimmune hepatitis ☐Wilsons disease ☐Viral Hepatitis	☐CBC ☐LFT ☐INR ☐Fasting Lipid Profile ☐Random Blood Glucose ☐Copper/Ceruloplasmin ☐Serum Alpha 1 Antitrypsin ☐IgG ☐Total Protein ☐Albumin ☐Abdominal Ultrasound	☐Community Dietitian referral ☐Fax referral to Peds GI for outpatient consultation
Fatty Liver with Transaminitis and normal BMI	**Assess for the following** ☐Metabolic syndrome ☐Autoimmune hepatitis ☐Wilsons disease ☐Viral Hepatitis	☐CBC ☐LFT ☐INR ☐Fasting Lipid Profile ☐Random Blood Glucose ☐Copper and Ceruloplasmin ☐Serum Alpha 1 Antitrypsin ☐IgG ☐Total protein ☐Albumin ☐Abdominal Ultrasound	☐Refer to General Pediatrician

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Gallstones	**Assess for Cholecystitis and Pancreatitis**	☐Fasting Lipid Profile ☐CBC ☐Morphology ☐Reticulocytes ☐LDH ☐Haptoglobin ☐Coombs ☐Lipase ☐Abdominal Ultrasound	☐Symptomatic with Gall Stones seen on Ultrasound in the CBD, call SFCC ☐If asymptomatic, fax referral to Peds GI for outpatient consultation
Gastroesophageal Reflux Disease	**GER is a normal physiological process** **GERD associated with the following:** ☐Failure to thrive ☐Sinusitis ☐Laryngitis ☐Chronic cough ☐Asthma ☐Pneumonia	☐Proton Pump Inhibitor prior to referral	☐Assessment by Pediatrician prior to GI referral ☐Fax referral to Peds GI for outpatient consultation
Hematemesis with Stable Hemoglobin	☐Confirm hemodynamic stability (age appropriate HR and BP) ☐Resuscitation if required ☐Signs of an upper GI bleed: melena hematemesis, hematochezia due to hemoglobin related catharsis	☐CBC ☐Lytes ☐BUN ☐Creatinine	☐Start Proton Pump ☐Call SFCC
Hepatomegaly	☐Assess for hyperbilirubinemia and splenomegaly	☐LFT ☐INR/PT ☐Abdominal Ultrasound with Doppler	☐Fax referral to Peds GI for outpatient consultation

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Hepatitis – Acute (ALT 10x ULN, normal INR)	☐Assess for acute liver failure INR>2 fully conscious child, INR>1.5 encephalopathic child ☐Screen for possible toxin ingestion and treat as per protocol.	☐Hep A IgM ☐HepBsAg ☐Hep C IgM ☐EBV ☐CMV ☐LFT ☐INR/PT ☐Random glucose ☐IgG ☐Total Protein ☐Albumin ☐Abdominal Ultrasound	☐ Fax referral to Peds GI for outpatient consultation
Hyperbilirubinemia in a child (Conjugated)	☐Assess for acute liver failure INR>2 fully conscious child, INR>1.5 encephalopathic child ☐Screen for possible toxin ingestion and treat as per protocol.	☐LFT ☐CBC ☐INR/PT ☐Random Glucose ☐CK ☐Hep A IgM ☐HepBsAg ☐Hep C IgM ☐EBV ☐CMV ☐Total Protein ☐Albumin ☐IgG ☐Abdominal Ultrasound	☐ Fax referral to Peds GI for outpatient consultation
Hyperbilirubinemia in a neonate (Conjugated)	**Definition:** **Conjugated bilirubin >17mmol/l or >20% conjugated fraction** ☐Biliary atresia is a time sensitive diagnosis ☐Document Acholic stool Fractionated bilirubin in neonates	☐Conjugated, Unconjugated and Total Serum Bilirubin ☐AST/ALT/GGT ☐TORCHES Screen ☐TSH ☐Urine Culture ☐Abdominal Ultrasound	☐ Fax referral to Peds GI for outpatient consultation
Hyperbilirubinemia in a neonate (Unconjugated)			☐Referral to General Pediatrician
Inflammatory Bowel Disease (Known)	☐Assess bowel symptoms (stool frequency< consistency, blood nocturnal) ☐Exclude non GI infections ☐Exclude enteric infection	☐Stool Culture/O&P/Viruses/ C.Diff ☐CBC ☐LFT ☐CRP ☐Albumin	☐If stable, fax referral to Peds GI for outpatient consultation ☐If unstable, call SFCC

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Inflammatory Bowel Disease (Suspected)	☐Assess for enteric infection ☐Patients undergoing endoscopic evaluation in non-pediatrics centers require both upper GI Endoscopy and Colonoscopy ☐Please see endoscopy biopsy site document for more details	☐Stool Culture/O& P/Viruses/ C.Diff ☐CBC ☐LFT ☐CRP ☐Albumin	☐ Fax referral to Peds GI for outpatient consultation
Iron Deficiency Anemia	☐Pediatric assessment prior to GI consult Exclude non GI causes ☐8 Weeks of iron supplementation with no demonstrable improvement in Hb or iron studies ☐Isolated FOB positive with no other signs will not be seen	☐CBC ☐Iron Studies ☐TTG-IgA/IgA ☐ESR/CRP ☐LFT ☐Albumin	☐ Fax referral to Peds GI for outpatient consultation
Liver Disease (Chronic/Portal Hypertension)	**Assess for complication of portal hypertension** ☐GI bleed ☐Sepsis ☐Ascites ☐Fat soluble vitamin deficiency ☐Decreased GCS ☐Abnormal renal function ☐Dyspnea	☐LFT ☐INR/PT ☐CBC ☐Abdominal Ultrasound	☐Call SFCC
Liver Enzymes (Abnormal on 2 occasions over 3-6 months)	☐Assess for acute liver failure INR>2 fully conscious child, INR>1.5 encephalopathic child ☐Screen for possible toxin ingestion and treat as per protocol.	☐Hep A IgM ☐HepBsAg ☐Hep C IgM ☐EBV ☐CMV ☐LFT ☐INR/PT ☐IgG ☐Total Protein ☐Albumin ☐Copper and Ceruloplasmin ☐Abdominal Ultrasound	☐Fax referral to Peds GI for outpatient consultation
Liver Transplantation	☐Screen for infection	☐LFT ☐INR/PT ☐Abdominal Ultrasound with Doppler	☐Call SFCC

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Pancreatitis (chronic/recurrent)	**Assess for acute or chronic presentation** ☐Pseudocyst formation ☐SIRS ☐Hypotension and Hemodynamic instability	☐BUN ☐Extended Lytes ☐Creatinine ☐Lipase ☐Fecal Elastase ☐Random Glucose ☐Abdominal Ultrasound	☐If stable, fax referral to Peds GI for outpatient consultation ☐If unstable, call SFCC
Perianal Abscess (recurrent non resolving)	☐Screen for signs and symptoms of IBD ☐In young males search for other evidence of soft tissue infection	☐CBC ☐LFT ☐CRP ☐Albumin ☐Stool Culture/O&P/ C.Diff	☐ Fax referral to Peds GI for outpatient consultation
Persistent Vomiting/Nausea	**Red flags:** ☐Bilious vomiting ☐Abdominal distention ☐Red currant jelly stool ☐No passage of gas or stool per rectum	☐CBC ☐BUN ☐Lytes ☐Creatinine ☐Blood Gas (if acutely ill) ☐Assess for signs of raised intracranial pressure ☐Abdominal Ultrasound as indicated ☐Upper GI Contrast Study as indicated	☐If presence of red flags signs, refer to Pediatric Surgery ☐If stable with history of chronic vomiting, fax referral to Peds GI for outpatient consultation
Polyposis	**Red flags:** ☐Bilious vomiting ☐Abdominal distention ☐No passage of gas or stool per rectum	☐Previous endoscopic reports and histology	☐If presence of red flags signs, call SFCC ☐If stable, fax referral to Peds GI for outpatient consultation
Rectal Bleeding	**Red flags:** ☐Exclude constipation ☐Check for anal fissure	☐CBC ☐LFT ☐CRP ☐Albumin ☐Stool Culture/O&P/ C.Diff	☐ Fax referral to Peds GI for outpatient consultation
Short gut syndrome	Any patient with a central line in place should be screened for sepsis if febrile		☐All Intestinal Failure patients are currently managed out of province by Calgary GI ☐Call SFCC

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GI Service Non-Urgent Triage Guidelines

Indications	Mitigating Factors	II <3wk	III <6wk	IV <3mo	V <6mo	VI <1yr
1. Abdominal pain (chronic/recurrent)	IBS/Functional				X	
	Non IBS			X		
2. Celiac disease (elevated TTg-IgA)	Asymptomatic			X		
	Mildly symptomatic		X			
	Very symptomatic	X				
	On gluten free diet				X	
3. Chronic diarrhea (>4weeks)	Suspect IBD	X				
	Normal growth			X		
	FTT/abnormal labs		X			
4. Constipation						X
5. Dysphagia	Isolated			X		
	Loss of weight		X			
6. Failure to Thrive	Normal Velocity			X		
	Crossing percentiles		X			
7. Fatty liver	Mildly elevated LFTs				X	
8. Gallstones	Asymptomatic					X
9. GERD	Mild symptoms			X		
	Severe symptoms	X				
	Failure to thrive	X				
10. Hepatomegaly/Splenomegaly	Isolated		X			
	FTT/abnormal labs	X				
11. Hepatitis (increased LFTs)	INR>2 URGENT					
	INR mildly increased	X				
	LFTs >100	X				
	LFTs<100			X		
12. Hyperbilirubinemia (Conjugated)	<4mo & Acholic stool URGENT CLINIC					
	<4mo colored stool		X			
	>4mo colored stool		X			
13. Iron deficiency anemia	Abnormal Iron Studies and HB on Iron supplementation		X			
14. Pancreatitis (chronic)	FTT/Abnormal labs	X				
	Normal labs		X			
15. Perianal abscess		X				
16. Persistent vomiting	Normal labs				X	
	Abnormal labs		X			
17. Polyps	Normal labs				X	
18. Rectal bleeding	Normal labs/painless			X		
	Abnormal labs/SX	X				

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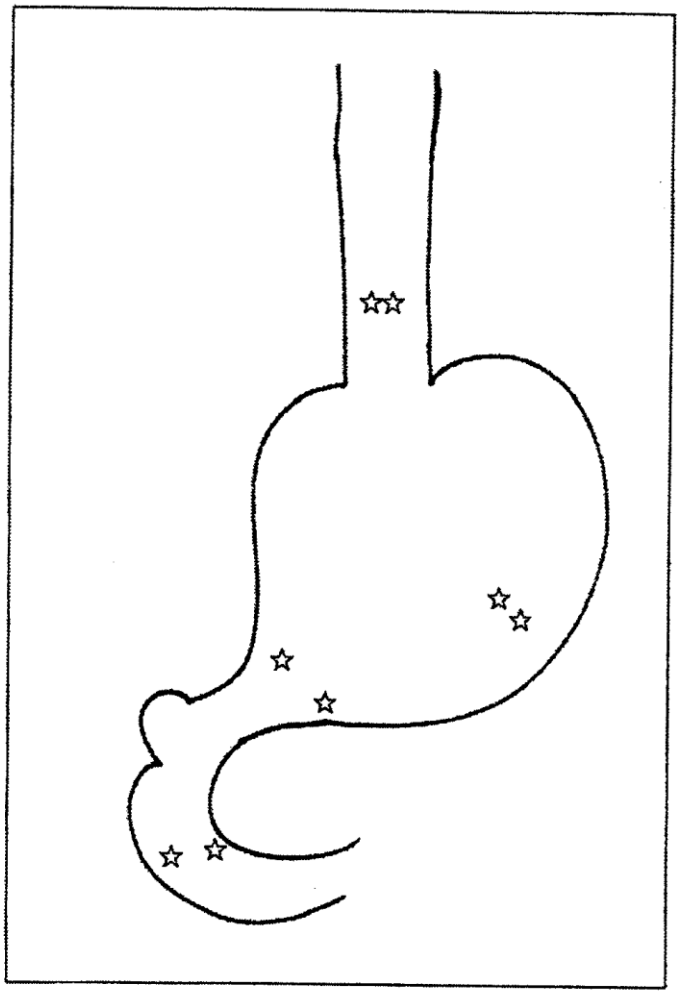
Location of Biopsies for "Routine/Normal" Upper Endoscopy



2 biopsies in 3rd portion of duodenum
2 biopsies in antrum – between incisura and pylorus (not next to pylorus)
2 biopsies in body of stomach
2 biopsies from the same level 3 or 5 cm above the pinch/GE junction
(depending on size of child)

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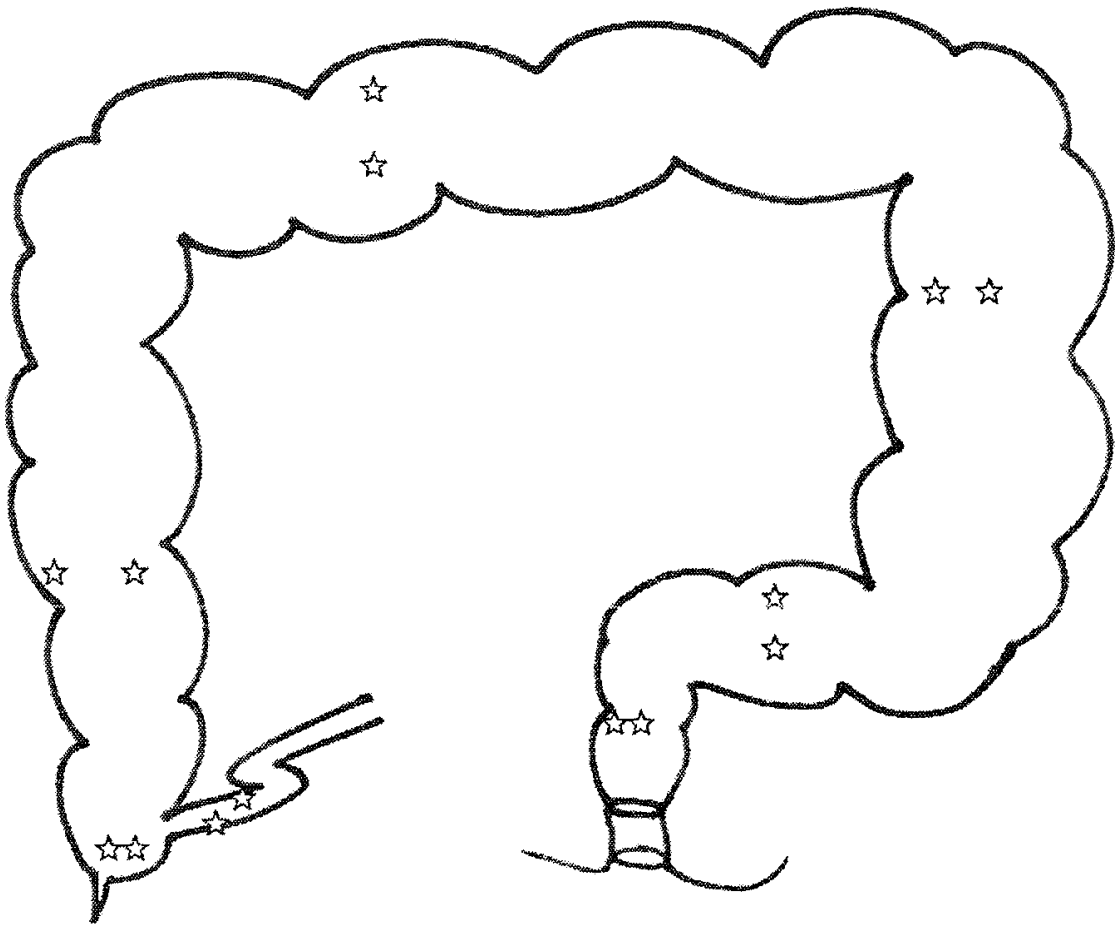
Colon Biopsy Location – Routine



2 biopsies from the – Terminal ileum
2 biopsies from the – Cecum
2 biopsies from the – Ascending Colon
2 biopsies from the – Transverse Colon
2 biopsies from the – Descending Colon
2 biopsies from the – Sigmoid Colon
2 biopsies from the - Rectum