Patient label placed here (if applicable) or if labels are not used, minimum information below is required.

Name (last, first) ________________________________

Birthdate (yyyy-Mon-dd) ________________________

Phone number ________________________________

Address ______________________________________

PHN ______________________ Gender ______________

High Risk Iron Deficiency Anemia (IDA) Pathway for Colorectal and other GI Cancer Diagnoses – Referral Checklist

Fax referral form AND referral checklist below to
SHARP-GI in Edmonton at 780-670-3607 or GI-CAT in Calgary at 403-944-6540

REQUIRED FOR REFERRAL - High risk IDA must be accompanied by presence of urgent or semi-urgent symptoms below to proceed with referral using the high risk IDA pathway

Signs of Iron Deficiency Anemia (IDA) – BOTH must be present to meet criteria for High Risk IDA

☐ Hb <130g/L (male) or <120g/L (female), **AND** ☐ Serum Ferritin below lower limit of normal

REQUIRED FOR URGENT REFERRAL – Should be evaluated within 2 weeks by colonoscopy

☐ IDA with Hb <110 g/L (Men) / <100 g/L (Women), **OR**

IDA with at least one of the following alarm symptoms not previously investigated by complete colonoscopy in the last 2 years (check all that apply):

☐ Significant diarrhea, as can occur in inflammatory bowel disease (IBD)
☐ Unintentional weight loss (≥ 5-10% of body weight over 6 months)
☐ Significant and progressive change in bowel habit
☐ Significant abdominal pain

REQUIRED FOR SEMI-URGENT REFERRAL – Should be evaluated < 8 weeks by colonoscopy

☐ IDA with Hb between 110-130 g/L (Men) **OR**
☐ IDA with Hb between 100-120 g/L (Women)

INVESTIGATIONS THAT WILL ASSIST WITH TRIAGE *(check all that apply)*

☐ Anti-platelet agents and/or anti-coagulants (please attach medication list)

☐ Results of physical exam (rectal exam strongly advised if change in bowel habit, or lower abdominal pain):

____

Baseline Investigations within 8 weeks of referral – results attached ☐ available on Netcare ☐

☐ **CBC (Required)**	☐ Transferrin Saturation	☐ ALT
☐ **Serum Ferritin (Required)**	☐ Creatinine	☐ CRP (if indicated)
☐ **TTG (Required)**	☐ Alkaline Phosphatase	
☐ Serum Iron	☐ Bilirubin	
☐ TIBC		

Type of referral	**Is your patient aware of the referral?**
☐ Urgent (< 2 weeks to gastroscopy and/or colonoscopy) ☐ Semi-urgent (< 8 weeks to gastroscopy and/or colonoscopy)	☐ Yes ☐ No Reason:________________________

Referred By (Name): __________________________ Family Physician Name (if different): ____________________

☐ Family Physician ☐ Walk-In Clinic ☐ Emergency Dept. ☐ Other