DIRECT-TO-PROCEDURE (DTP)

Referrals triaged direct-to-procedure have a clear and specific indication, investigation of which appropriately begins with an endoscopic procedure for efficiency of process and facilitation of care. The patient's background history is not complex and can be addressed in a 15-minute consultation. Patients with serious or unstable cardiac, pulmonary or renal issues are not appropriate for DTP. Patients aged ≥70 require nursing history. DTP process ensures that patients are informed in advance via telephone of the general rationale and risks of the test for the purpose of procedural consent.

Excluded from DTP:

1. Active or unstable disease
   - Exertional chest pain
   - Congestive heart failure
   - Myocardial infarction or stroke within 6 months
   - Respiratory disease requiring home oxygen
   - Chronic renal failure requiring dialysis
2. Complex or multiple medical problems
3. Significant language barrier
4. Major psychiatric or psychological disease
5. Cognitive impairment or dementia
6. Abdominal pain (since often requires more than a 15 minute assessment)
7. Patients age ≥80 for colonoscopy

Not excluded from DTP:

1. Anti-coagulant therapy
2. Insulin-dependent diabetes
3. MI or cardiac issues that occurred > 6 months ago
4. Obesity
5. Obstructive sleep apnea
6. Implantable cardioverter-defibrillator must be identified clearly on referral as there are implications for use of bipolar cautery in these patients

If unsure about suitability of a patient for DTP pathway, forward to Medical Lead for review.

SEEN BEFORE

If referred patient has seen a GI CAT physician within the last 5 years, send as "Seen Before" to that physician to triage.

CASE DISCUSSED WITH…

If referral states "case discussed with" any attending GI physician, referral package goes directly to that physician as details of case and plan of action are often not specified. If the referral is urgent in nature and the "discussed with" physician is not available to triage, then send to Medical Lead.

SPECIFIED GASTROENTEROLOGIST

If referral specifies preference for a particular gastroenterologist, triage to that GI, if timeline can be met.

SECOND OPINION

All referrals for second opinion are to be triaged by Medical Lead.

THIN SCOPE ENDOSCOPY (TSE)

Patients referred for assessment of positive celiac serology.

- There are no specific predictors of patients that will not tolerate TSE

SPECIALTY PROCEDURES AND CLINICS FOR MD/NP TRIAGE

Barrett's Esophagus	Dr. Belletrutti Dr. Gupta
Capsule Endoscopy	Dr. Buresi
Confocal Endoscopy and IBD Dysplasia Screening	Dr. Iacucci
Double Balloon Endoscopy	Dr. Love Dr. Kumar
Esophageal Manometry	Dr. Buresi Dr. Curley Dr. Gupta
ERCP	Dr. Heitman Dr. Mohamed **(<u>if urgent</u>, contact on call ERCP physician)**
EUS	Dr. Belletrutti Dr. Kumar Dr. Mohamed Dr. Nash
Gastroparesis	Dr. Andrews Dr. Buresi
IBD	Joan Heatherington
IBD Pregnancy	Dr. Leung Dr. Seow

Malnutrition	Dr. Raman Dr. Stapleton
PSC	Dr. Eksteen

PEDIATRIC TRANSITION (ages 17-18)

Patients age <17 years are to be redirected to pediatric GI at ACH. All patients aged 17-18 years referred to CAT from any source are to be triaged by Medical Lead.

- Age 17 $^{9}/_{12}$ with urgent GI issue will be dealt with via existing urgent pathways
- Age 17-18 with moderate/routine GI issue will be triaged according to pediatric GI timelines and consider severity and impact (e.g. missing school) of the referring problem. If referral is a redirect from pediatric GI, GI CAT will backdate to time of original referral
- Pediatric IBD Transition - Joan Heatherington

URGENT+ ENDOSCOPY (< 2 weeks)

These are urgent referrals for GI consultation and endoscopic procedures (usually EGD, rarely colonoscopy), and are dealt with by the Service Endoscopist.

- Upper GI series suggestive of cancer
- Progressive dysphagia
- Hematemesis or coffee ground emesis with low hemoglobin
- Barium enema or CT scan suggestive of colorectal cancer

All patients triaged to Urgent+ Endoscopy pathway require review by Medical Lead

URGENT+ CLINIC (< 4 weeks)

These are urgent referrals for an endoscopic procedure, but the fitness of the patient and/or the appropriateness of endoscopic procedure need to be determined by initial consultation in clinic. Urgent+ Clinic cases are paired with endoscopy time within 4 weeks of clinic.

- Do not meet criteria for DTP or Urgent+ Endoscopy pathways
- FIT+ patients that do not meet criteria for DTP

GI FELLOWS CLINIC

- All cases should be urgent

MANDATORY INVESTIGATIONS

There are specific referral indications that require essential investigations to guide appropriate triage. Referrals that do not have these mandatory investigations will be closed. Referring physicians will be advised to submit a new referral once the mandatory investigations are complete. This policy of cancellation reduces the number of referrals that remain unprocessed, pending further information.

ABDOMINAL PAIN

Mandatory Investigations		
	☐ CBC, ferritin	☐ Celiac serology
	☐ ALT, ALP, GGT, bilirubin, albumin, lipase	☐ Urea breath test
	☐ CRP	☐ Abdominal ultrasound

Acute (<3 months) and/or abnormal bloodwork or ultrasound

- MD to triage

Chronic (>3 months) and normal investigations

- Moderate to clinic

ABNORMAL IMAGING

Any radiologic findings suggestive of malignancy

- Urgent+ Endoscopy if possible upper GI cancer
- MD to triage if possible lower GI cancer

Abnormal UGI Series

- Urgent+ Endoscopy

All other radiographic abnormalities

- MD to triage

IRON DEFICIENCY ANEMIA

Mandatory Investigations		
	☐ Comment on signs of GI blood loss	☐ Celiac serology
	☐ CBC, ferritin	☐ CRP

Low hemoglobin and ferritin <75

Age <40

- Urgent+ Clinic

Age ≥40

- DTP EGD and colonoscopy

Low hemoglobin and ferritin >75

- If no signs of GI bleeding and/or no GI symptoms, send *Hematology Investigation Letter*
- Otherwise, MD triage

GASTROINTESTINAL BLEEDING

Mandatory Investigations	☐ Family history of CRC or polyps ☐ CBC, ferritin

If any concern about acuity or severity of presentation, advise referring MD to discuss with GI on call or send patient to ER.

Melena

- Urgent+ Endoscopy (then decision about colonoscopy by attending GI)

"Outlet" rectal bleeding (bright red blood with defecation, no change in bowel habit)
+ recent normal Hgb and ferritin if present, but do not make triage pending lab work

- Age <50, Sigmoidoscopy Clinic (Urgent DTP Colonoscopy if FHx CRC/polyp in 1st degree relative, weight loss, change bowel habit)
- Age ≥50, Urgent DTP colonoscopy

Fresh or maroon blood mixed with stools

- Urgent DTP colonoscopy

CELIAC DISEASE

Newly detected positive celiac serology

- If antiTTG+ and antiEMA+ triage to TSE clinic within 8 weeks
- If antiTTG+ but antiEMA- and no red flags, cancel referral and send letter asking refMD to repeat celiac serologies then send in new referral with those results and checklist of additional clinical detail (e.g. timelines and progression of symptoms, ROME criteria questions, NSAID use, inflammatory markers, etc.)

Known celiac disease with symptoms

- Moderate to clinic (mandatory investigation: celiac serology, CBC, ferritin)
  MD review if red flag signs, symptoms, or lab results

CHANGE IN BOWEL MOVEMENT

Change in stool shape, calibre, character, or bowel habit

- MD Triage

CONSTIPATION

Acute (< 3 months)

- MD Triage

Chronic (> 3 months)

- No evidence that these are high yield if patients are committed to colonoscopy, even if > age 50
- Primary Care in the Medical Home – Specialist Consultation Unnecessary
- Closed referral provides an Enhanced Care Pathway to the referring MD

DIARRHEA

Mandatory Investigations	☐ CBC, ferritin	☐ Cdiff, O&P direct exam, C&S
	☐ Albumin, CRP	☐ Stool leukocytes, elastase
	☐ Celiac serology	☐ Stool pH, fat globules

Diarrhea with anemia, iron deficiency, elevated CRP and/or red flags (bleeding, fecal incontinence, weight loss)

- IBD Nurse Practitioner to triage

Acute diarrhea (<4 weeks)

- MD Triage

Chronic diarrhea (>4 weeks) with normal labs and no red flags

- Moderate to clinic; ensure mandatory investigations complete

DIVERTICULITIS

Request for colonoscopy after acute uncomplicated diverticulitis

- Urgent DTP colonoscopy (time sensitive - no sooner than 4 weeks from time of symptom resolution after acute attack; redirect to CCSC if meet usual criteria)

Request for colonoscopy after acute complicated diverticulitis (CT shows perforation, abscess, obstruction)

- Redirect to colorectal surgery

Acute flare

- MD to Triage

DYSPEPSIA

Red flags: Vomiting, Bleeding, Anemia, Dysphagia, (VBAD), age >55 with new symptoms

- Urgent DTP EGD

Otherwise

- Primary Care in the Medical Home – Specialist Consultation Unnecessary
- Closed referral provides an Enhanced Care Pathway to the referring MD
- Dovetails with Nurse Navigator pathways or Nurse-led group sessions available at some PCN's

GERD

Red flags: Vomiting, Bleeding, Anemia, Dysphagia (VBAD)

- Urgent DTP EGD

Otherwise

- Primary Care in the Medical Home – Specialist Consultation Unnecessary
- Closed referral provides an Enhanced Care Pathway to the referring MD
- Dovetails with Nurse Navigator pathways or Nurse-led group sessions available at some PCN's

REFRACTORY AND RECURRENT HELICOBACTER PYLORI

Collect information about past attempts at treatment

- Print all available pharmacy information from Netcare
- Medical Lead to review re: advice on next attempt at Hp treatment vs EGD for biopsy and C&S
- If the patient is presently on Hp treatment or there is no UBT after last treatment, send closed referral letter.

DYSPHAGIA

New/progressive dysphagia, red flags (anemia, vomiting, weight loss, bleeding) **abnormal UGI series**

- Urgent+ Endoscopy

All other dysphagia

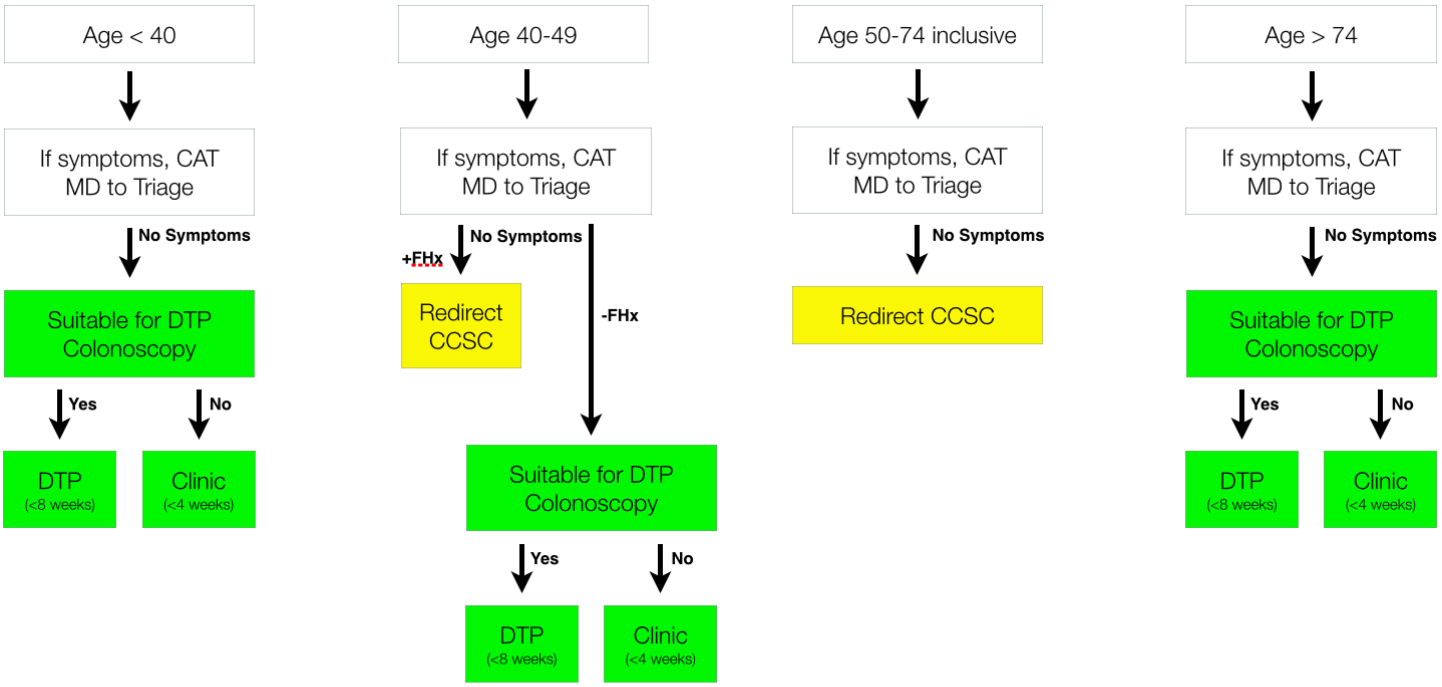
- Urgent DTP EGD

Schatzki ring or peptic stricture with previous dilatations

- Urgent DTP EGD

FECAL IMMUNOCHEMICAL TEST

See algorithm below:



FHx = Family history of CRC, specifically first degree relative with CRC at any age; guidelines support screening such patients beginning at age 40

Interval FIT+ defined as normal screening colonoscopy within three years of new FIT+

- Send *Interval FIT+ Letter* to referring MD
- Forward referral directly to physician that did last colonoscopy for case-by-case assessment. This applies to any physician, whether CAT-affiliated or not.

AVERAGE RISK COLON CANCER SCREENING

Patients that do not qualify at CCSC

- Routine DTP colonoscopy

SURVEILLANCE COLONOSCOPY

Patients that do not qualify at CCSC

- Important to obtain all available colonoscopy and polyp histopathology reports
- 'Seen before' physician if ≤5 years
- MD Triage otherwise

BARRETT'S SCREENING

Chronic GERD (≥10 years) for initial Barrett's screening

- DTP Routine EGD if patient has ANY 2 or more of the following risk factors:
  Obese (BMI > 30; or waist circumference >35 inches [women] or >40 inches [men])
  White
  Male
  Hiatal hernia
  > 50 years of age
  Positive family history of esophageal cancer or Barrett's
- Belletrutti/Gupta to review for Barrett's Clinic at SHC

If no risk factors and GERD well controlled

- Close referral for screening

BARRETT'S SURVEILLANCE

Important to obtain all available EGD and histopathology reports

- Belletrutti/Gupta to review for Barrett's Clinic at SHC

GASTRIC CANCER SCREENING

Mandatory Investigations	☐ Urea Breath Test in last 12 months

If *Hp* positive, cancel referral and recommend *Hp* eradication and follow-up UBT

- Suggest call to GI Specialist Link if referring MD requires advice about Hp treatment regimen

High risk groups

- DTP Routine EGD if patient has:
  Atrophic gastritis and extensive intestinal metaplasia
  Pernicious anemia
  Partial gastrectomy
  History of gastric adenoma
  First degree relative with gastric cancer

Not high risk group

- Close referral for screening
  It is impractical and of uncertain validity to offer gastric cancer screening to all patients only on the basis of higher risk ethnicity

IRRITABLE BOWEL SYNDROME

Described symptoms are consistent with IBS (abdominal pain with constipation, diarrhea, or alternating periods of both, no red flags, no relevant family history, normal CBC, CRP, negative celiac screen).

- Primary Care in the Medical Home – Specialist Consultation Unnecessary
- Closed referral provides an Enhanced Care Pathway to the referring MD
- Dovetails with Nurse Navigator pathways or Nurse-led group sessions available at some PCN's

Ongoing IBS symptoms despite attempts by GP to treat

- Routine to clinic
- Direct referring physician to resources in Enhanced Care Pathway

PE/DVT

For investigation of occult GI malignancy

- Patients are usually referred acutely and on anticoagulation
- Medical Lead to triage, likely recommend CT colonography

VOMITING

- MD to Triage

FECAL INCONTINENCE

Devastating to quality of life

- Should be triaged as urgent to clinic at SHC for access to manometry

TRANSPLANT PATIENTS

Pre-transplant screening colonoscopy

- Urgent DTP colonoscopy

Post-transplant screening colonoscopy

- Routine DTP colonoscopy

Post-transplant patient with any GI symptoms

- Urgent Clinic or GI Fellows' Clinic

WEIGHT LOSS:

Mandatory Investigations	☐ Documentation of degree and timeline of weight loss (e.g. refMD clinic records)

If rapid (>25lbs in 3 months)

- Urgent to clinic

Otherwise

- MD to triage

Alberta Health Services

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Dr. Melanie Stapleton

IBD Nurse Practitioners

Joan Heatherington
Marie-Louise Martin

Name:	DOB:
PHN/ULI:	RHRN:
RefMD:	RefMD Fax:
RefDate:	Date Today: March 8, 2016

IMPORTANT NOTICE

Closed GI Referral: Mandatory Investigations

Dear ,

The above-named patient was referred to GI Central Access and Triage (CAT). A focused review of Netcare reveals specific investigations that are missing or out of date, as indicated below. These data are relevant to the presenting GI issue and are important in deciding appropriate triage pathway and priority.

☐ **ABDOMINAL PAIN**

CBC	Celiac Disease Screen	Abdominal Ultrasound
Ferritin	Urea Breath Test	ALT, ALP, GGT, Bili
Albumin	CRP	Lipase

☐ **CHRONIC DIARRHEA**

CBC	Celiac Disease Screen	Stool Fat Globules, Random (ONLY IF steatorrhea or other features of malabsorption)
Ferritin	Stool *Clostridium difficile*	
Albumin	Stool O&P (ONLY IF relevant clinical, exposure or travel history, CLS form #MI6011)	
CRP		

☐ **GASTROINTESTINAL BLEEDING**

CBC	Family history of CRC/polyps or other GI malignancy
Ferritin	More detail on specific features of GI bleeding

☐ **IRON DEFICIENCY ANEMIA**

CBC	Family history of CRC/polyps or other GI malignancy
Ferritin	Detailed menstrual history in females
CRP	Date anemia was first documented
Celiac Disease Screen	Comment on signs of GI bleeding

This referral is CLOSED. Once the requested investigations have been completed, please fax a new referral to GI CAT at 403-944-6540.

Thank you.

Kevin Rioux, MD PhD FRCPC
Medical Lead, Central Access and Triage
Section of Gastroenterology

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Name:	DOB:
PHN/ULI:	RHRN:
RefMD:	RefMD Fax:
RefDate:	Date Today: March 8, 2016

IMPORTANT NOTICE

Closed GI Referral: Redirect to Hematology

Dear ,

The above-named patient was referred to GI Central Access and Triage (CAT) for assessment of anemia. Based on laboratory criteria - **low hemoglobin, ferritin >75, normal MCV** - it is unlikely that this patient's anemia is due to chronic GI blood loss or iron malabsorption.

If this patient has GI symptoms or overt signs of GI blood loss, please send a new referral to GI CAT providing specific clinical details.

Otherwise, to further characterize this patient's anemia, please consider:

- Evaluation of the bone marrow response - **reticulocyte count and peripheral blood smear**
- Factors in RBC production - **vitamin B12, folate;** recheck **ferritin**
- Assessment of hemolysis - **LDH, haptoglobin, peripheral blood smear, total and direct bilirubin; DAT if suspect autoimmune hemolysis**
- Rule out multiple myeloma - **SPE and β2-microglobulin**

This referral is CLOSED. Please consider redirecting your referral to Hematology.

If you have any questions or concerns, please contact us via fax at 403-944-6540.

Thank you.

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Name:	DOB:
PHN/ULI:	RHRN:
RefMD: Dr.	RefMD Fax:
RefDate:	Date Today: March 8, 2016

IMPORTANT NOTICE

Closed GI Referral: Indications for Barrett's Screening Not Specified

Dear Dr. ,

The above-named patient was referred to GI Central Access and Triage (CAT) for Barrett's Esophagus screening. According to AHS Clinical Practice Guideline GI-011, screening endoscopy is indicated if the following conditions are met:

- ☐ **Chronic GERD (≥10 years) plus two or more risk factors:**
  - ☐ >50 years of age
  - ☐ Male gender
  - ☐ Caucasian
  - ☐ BMI ≥30
  - ☐ Waist circumference >35" for females or >40" for males
  - ☐ Hiatal hernia (demonstrated radiographically)
  - ☐ Family history of esophageal cancer or Barrett's
- ☐ **GERD is well controlled with once or twice daily PPI**

This referral is CLOSED. If your patient meets criteria for Barrett's screening, please submit a new referral to GI CAT, including the completed checklist above.

If you have any questions or concerns, please contact us via fax at 403-944-6540.

Thank you.

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Name:	DOB:
PHN/ULI:	RHRN:
RefMD:	RefMD Fax:
RefDate:	Date Today: March 8, 2016

NOTIFICATION OF TRIAGE DISPOSITION

Direct to Procedure (DTP) Pathway

Dear ,

The above-named patient was referred to GI Central Access and Triage (CAT). To aid assignment of triage priority and pathway, relevant information was pulled from Netcare. Your referral was assessed by a GI nurse and/or GI physician and deemed appropriate for same-day GI consultation and endoscopy via the DTP Pathway:

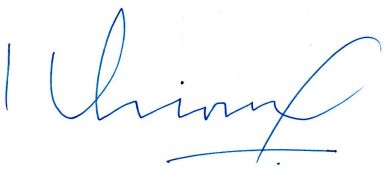
- ☐ **Urgent+ (< 2 weeks)**
- ☐ **Urgent (< 8 weeks)**
- ☐ **Moderate (< 20 weeks)**
- ☐ **Routine (>52 weeks)**

A GI Nurse will contact your patient to ensure they are suitable for DTP on medical grounds (e.g. cardiac and pulmonary status, anticoagulation, etc.). Your patient will then be provided appointment details and preparation instructions.

If your patient is not suitable for DTP, they will be booked instead for a clinic appointment at the same priority level.

If you have any questions or concerns, please contact us via fax at 403-944-6540.

Thank you.



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PHN/ULI:	RHRN:
RefMD:	RefMD Fax:
RefDate:	Date Today: March 8, 2016

NOTE TO REFERRING PHYSICIAN

Dear ,

If you have any questions or concerns, please contact us via fax at 403-944-6540.

Thank you.

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RefDate:	Date Today: March 8, 2016

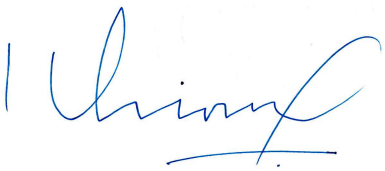
IMPORTANT NOTICE

Closed GI Referral

Dear ,

If you have any questions or concerns, please contact us via fax at 403-944-6540.

Thank you.



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PHN/ULI:	RHRN:
RefMD:	RefMD Fax:
RefDate:	Date Today: March 8, 2016

IMPORTANT NOTICE

Closed GI Referral: Patient Declined Appointment

Dear ,

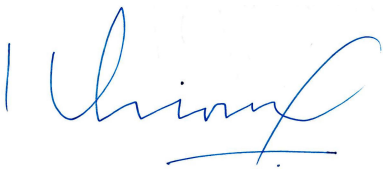
The above-named patient was referred to GI Central Access and Triage (CAT) and approved for clinic consultation or endoscopic procedure.

Your patient was contacted by our booking staff and offered an appointment, which the patient declined.

Your patient was advised to re-discuss with you the nature of the referral. If there is ongoing need for GI services, please submit a new referral to CAT.

If you have any questions or concerns, please contact us via fax at 403-944-6540.

Thank you.



Kevin Rioux, MD PhD FRCPC
Medical Lead, Central Access and Triage
Section of Gastroenterology

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PHN/ULI:	RHRN:
RefMD:	RefMD Fax:
RefDate:	Date Today: March 8, 2016

IMPORTANT NOTICE

Closed GI Referral: Patient Already Seen by GI for Same Indication

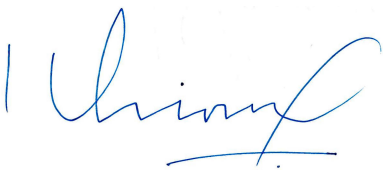
Dear ,

The above-named patient has already been assessed by Gastroenterology for the same clinical indication that prompted your referral to GI Central Access and Triage (CAT). Dr. saw your patient on for consultation and/or endoscopic procedure.

To avoid duplication of service, GI CAT has closed this referral.

If you have any questions or concerns, please contact us via fax at 403-944-6540.

Thank you.



Kevin Rioux, MD PhD FRCPC
Medical Lead, Central Access and Triage
Section of Gastroenterology