PEDIATRIC GASTROENTEROLOGY
HEPATOLOGY and NUTRITION
REFERRAL REQUEST

REFERRING PROVIDER (NAME/FAX/SPECIALTY):

REASON FOR REFERRAL:

RELEVANT HISTORY:

CURRENT MEDICATIONS:

TEST RESULTS (PLEASE ATTACH OR WRITE BELOW):
CRP: OTHER:
CBC: ALBUMIN:
CELIAC SCREEN: TOTAL IMMUNOGLOBULINS:

REQUIRED INFORMATION:
☐ NEED FOR INTERPRETER? (LANGUAGE: ______________)
☐ GROWTH CHARTS HAVE BEEN ATTACHED

**ACCURATE COMPLETION OF THIS FORM WILL HELP TRIAGE YOUR PATIENT MOST EFFICIENTLY
IF CONCERNS FOR AN EMERGENCY or URGENT CONSULT PLEASE REQUEST TO SPEAK DIRECTLY TO
PEDIATRIC GI ON-CALL 905 521 5030

FAX TO 905 521 2627

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