# BC Children's Hospital Outpatient G-Tube Referral Form

**Fax completed forms to 604 642 8890**

Today's Date:

## REFERRING DOCTOR INFORMATION

| Physician Name: | MSP #: | Fax: |
|---|---|---|

## PATIENT INFORMATION

| Patient's last name: | First: | DOB (dd/mm/yyyy): |
|---|---|---|

| BCCH MRN # | Sex: ☐ M ☐ F | Interpreter required: ☐ Yes ☐ No |
|---|---|---|
| PHN: | | Language: _____ |

Address: [Street Address, City/Town, BC, Postal Code]

| Home phone #: | Cell phone #: |
|---|---|

## MEDICAL HISTORY

Primary Diagnosis:

Secondary Diagnoses:

### INDICATION (select all that apply)

| **Failure To Thrive** ☐ | **Dysphagia** ☐ | **Aspiration** ☐ | **Administration of:** | **Other**: |
|---|---|---|---|---|
| Poor Intake ☐ | Oromotor Dysfunction ☐ | Risk of Aspiration ☐ | Medications ☐ | |
| Malabsorption ☐ | Esophageal (ex. GERD, EoE) ☐ | Proven Aspiration ☐ | Hydration ☐ | |
| Increased demands ☐ | Pre-Oral (psychological) ☐ | | | |

## Diet & Feeding History

| Weight (kg) | Weight (%) | Height (cm) | Height (%) |
|---|---|---|---|

| Current Feeding | Oral ☐ | If oral, type of feeds Liquids ☐ Purees ☐ Solids ☐ |
|---|---|---|
| | NG ☐ | If ng, when was this started: |

| Formula used | Volume per day (ml) |
|---|---|
| % of calories estimated will come from G tube feeds (0 – 100%) | |

| Dietitian Involved | ☐ Yes ☐ No | If Yes, Name: |
|---|---|---|
| Feeding Study performed (ex VFFS) | ☐ Yes ☐ No | If Yes, please include report |
| Feeding Therapist involved (OT/ SLP) | ☐ Yes ☐ No | If Yes, Name: Agency: |
| Where will funding for Gtube supplies & formula come from? | | |
| Please describe parents' / patient's current perspective on getting a G tube: | | Very interested / Moderately interested / Need more information / Other _____ |

| Would you like a (2nd opinion) medical review related to the appropriateness of a Gtube in this patient? | ☐ Yes ☐ No | |
|---|---|---|
| Will you be the most responsible physician following this patient's feeding and nutrition over the next few years? | ☐ Yes ☐ No | If not, who will be the MRP? |
| Other Comments: | | _____ ***Referring Physician's Signature*** |

Required Attachments: Growth Chart ☐ Recent patient report / Medical summary ☐ Investigations (optional): ex VFFS ☐



Office only: Received _____