



Today's Date:				
<b>REFERRING DOCTOR INFORMATION</b>				
Physician Name:		MSP #:	Fax:	
<b>PATIENT INFORMATION</b>				
Patient's last name:		First:	DOB (dd/mm/yyyy):	
BCCH MRN #		Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Interpreter required: <input type="checkbox"/> Yes <input type="checkbox"/> No	
PHN:			Language: _____	
Address: [Street Address, City/Town, BC, Postal Code]				
Home phone #:			Cell phone #:	
<b>MEDICAL HISTORY</b>				
Primary Diagnosis:				
Secondary Diagnoses:				
<b>INDICATION (select all that apply)</b>				
<b>Failure To Thrive</b> <input type="checkbox"/> Poor Intake <input type="checkbox"/> Malabsorption <input type="checkbox"/> Increased demands <input type="checkbox"/>	<b>Dysphagia</b> <input type="checkbox"/> Oromotor Dysfunction <input type="checkbox"/> Esophageal (ex. GERD, EoE) <input type="checkbox"/> Pre-Oral (psychological) <input type="checkbox"/>	<b>Aspiration</b> <input type="checkbox"/> Risk of Aspiration <input type="checkbox"/> Proven Aspiration <input type="checkbox"/>	<b>Administration of:</b> Medications <input type="checkbox"/> Hydration <input type="checkbox"/>	<b>Other:</b>
<b>Diet &amp; Feeding History</b>				
Weight (kg)	Weight (%)		Height (cm)	Height (%)
Current Feeding	Oral <input type="checkbox"/>	If oral, type of feeds Liquids <input type="checkbox"/> Purees <input type="checkbox"/> Solids <input type="checkbox"/>		
	NG <input type="checkbox"/>	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		<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Name:	
Feeding Study performed (ex VFFS)		<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, please include report	
Feeding Therapist involved (OT/ SLP)		<input type="checkbox"/> Yes <input type="checkbox"/> 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?			<input type="checkbox"/> Yes <input type="checkbox"/> No	
Will you be the most responsible physician following this patient's feeding and nutrition over the next few years?			<input type="checkbox"/> Yes <input type="checkbox"/> No	
If not, who will be the MRP?				
Other Comments:				_____ <i>Referring Physician's Signature</i>
Required Attachments: Growth Chart <input type="checkbox"/> Recent patient report / Medical summary <input type="checkbox"/> Investigations (optional): ex VFFS <input type="checkbox"/>				