

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

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 \_\_\_\_\_

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**

<input type="checkbox"/> <b>CBC (Required)</b>	<input type="checkbox"/> Transferrin Saturation	<input type="checkbox"/> ALT
<input type="checkbox"/> <b>Serum Ferritin (Required)</b>	<input type="checkbox"/> Creatinine	<input type="checkbox"/> CRP (if indicated)
<input type="checkbox"/> <b>TTG (Required)</b>	<input type="checkbox"/> Alkaline Phosphatase	
<input type="checkbox"/> Serum Iron	<input type="checkbox"/> Bilirubin	
<input type="checkbox"/> TIBC		

Type of referral	Is your patient aware of the referral?
<input type="checkbox"/> Urgent (< 2 weeks to gastroscopy and/or colonoscopy)	<input type="checkbox"/> Yes
<input type="checkbox"/> Semi-urgent (< 8 weeks to gastroscopy and/or colonoscopy)	<input type="checkbox"/> No Reason: _____

Referred By (Name): \_\_\_\_\_ Family Physician Name (if different): \_\_\_\_\_

Family Physician  Walk-In Clinic  Emergency Dept.  Other