

MEDICAL SUMMARY TEMPLATE FOR THE TRANSITION OF PATIENTS WITH INFLAMMATORY BOWEL DISEASE (IBD) FROM PEDIATRIC TO ADULT CARE

TO: ADULT PROVIDER

Provider Name: _____
Address: _____
Phone: _____
Fax: _____
Email: _____

TO: PEDIATRIC PROVIDER

Provider Name: _____
Address: _____
Phone: _____
Fax: _____
Email: _____

RE:

Name: _____
Preferred pronoun(s): _____
Date of Birth (MM/DD/YYYY): _____
Address: _____
Phone: _____
Email [patient]: _____
Email [parent]: _____

HIN#: _____

PRIORITY OF TRANSFER

- Urgent (within 3-months)
- Semi-urgent (within 6-months)
- Non-urgent (within 12-months, or within 6–12 months of 18th birthday)

ALLERGIES

Medications: _____

Other: _____



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PATIENT/DISEASE CHARACTERISTICS

DEMOGRAPHICS

- Date of birth (MM/DD/YYYY): _____
- Biologic sex (M/F/Intersex/Other): _____
- Patient's contact information:
 - Address: _____
 - Phone: _____
 - Email: _____

DIAGNOSIS AND PHENOTYPE

- Date of diagnosis (MM/DD/YYYY - at minimum, year of diagnosis): _____
- Disease type (CD, UC or IBD-U): _____
- Disease location: _____
- Phenotype (Paris or Montreal classification): _____

COMORBIDITIES/OTHER CHRONIC DIAGNOSES

- Related to IBD: _____

- Unrelated to IBD: _____

THERAPEUTICS / MEDICATIONS

MEDICATIONS CURRENT AND HISTORIC

(Please list in chronological order)

1. Medication name: _____
 - Dose: _____
 - Start date (MM/DD/YYYY): _____
 - Discontinuation date (MM/DD/YYYY): _____
 - Reason for stop, if applicable (e.g., side effects, complications, compliance, non-adherence): _____

2. Medication name: _____
 - Dose: _____
 - Start date (MM/DD/YYYY): _____
 - Discontinuation date (MM/DD/YYYY): _____
 - Reason for stop, if applicable (e.g., side effects, complications, compliance, non-adherence): _____

3. Medication name: _____
 - Dose: _____
 - Start date (MM/DD/YYYY): _____
 - Discontinuation date (MM/DD/YYYY): _____
 - Reason for stop, if applicable (e.g., side effects, complications, compliance, non-adherence): _____



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THERAPEUTICS / MEDICATIONS

BIOLOGICS

(Please list in chronological order)

1. Medication name: _____
 - Dose and interval (at initial induction): _____
 - Dose and interval (currently): _____
 - Reasons for escalation/de-escalation: _____
 - _____
 - Recent serum titers (Refer to Labs section below): _____
 - _____
2. Medication name: _____
 - Dose and interval (at initial induction): _____
 - Dose and interval (currently): _____
 - Reasons for escalation/de-escalation: _____
 - _____
 - Recent serum titers (Refer to Labs section below): _____
 - _____
3. Medication name: _____
 - Dose and interval (at initial induction): _____
 - Dose and interval (currently): _____
 - Reasons for escalation/de-escalation: _____
 - _____
 - Recent serum titers (Refer to Labs section below): _____
 - _____

CORTICOSTEROID HISTORY

(Please list in chronological order based on last course)

1. Medication name: _____
 - Number of courses: _____
 - Last course (MM/DD/YYYY): _____
 - Response (Dependent or Refractory): _____
 - _____
2. Medication name: _____
 - Number of courses: _____
 - Last course (MM/DD/YYYY): _____
 - Response (Dependent or Refractory): _____
 - _____
3. Medication name: _____
 - Number of courses: _____
 - Last course (MM/DD/YYYY): _____
 - Response (Dependent or Refractory): _____
 - _____

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THERAPEUTICS / MEDICATIONS

SURGICAL HISTORY

(Please list in chronological order, and include attachments for surgical and pathology reports)

1. Name/description (including length of bowel resected if available): _____

- Date (MM/DD/YYYY): _____
- Pathology report [insert attachment]: _____
- Reason for surgery: _____
- Post-surgical complications (if applicable [alternative: report in Complications section below]): _____

2. Name/description (including length of bowel resected if available): _____

- Date (MM/DD/YYYY): _____
- Pathology report [insert attachment]: _____
- Reason for surgery: _____
- Post-surgical complications (if applicable [alternative: report in Complications section below]): _____

3. Name/description (including length of bowel resected if available): _____

- Date (MM/DD/YYYY): _____
- Pathology report [insert attachment]: _____
- Reason for surgery: _____
- Post-surgical complications (if applicable [alternative: report in Complications section below]): _____



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CLINICAL HISTORY AND CURRENT STATUS

HISTORY OF PRESENTING ILLNESS

Initial presentation at diagnosis (brief description of initial presentation and clinical course):

• Status (provide disease activity index if possible):

Stable/controlled – disease activity index: _____

Unstable/uncontrolled – disease activity index: _____

• Significant physical findings, if applicable: _____

ANTHROPOMETRICS & CURRENT STATUS

• Weight: _____ kg • Height: _____ cm • Body mass index (BMI): _____ kg/m²

• Patient history of growth failure:

None/non-applicable

Growth failure history: _____

INVESTIGATIONS

IMAGING: ENDOSCOPIES

(Please attach endoscopy and pathology reports)

At diagnosis:

• Description: _____

• Date (MM/DD/YYYY): _____

• Disease location: _____

• Severity: _____

• Pathology report [insert attachment]: _____

At last endoscopy:

• Description: _____

• Date (MM/DD/YYYY): _____

• Disease location: _____

• Severity: _____

• Pathology report [insert attachment]: _____

Brief listing of other endoscopies (date, results) [insert attachment if applicable]: _____

If applicable: was cancer surveillance colonoscopy conducted or discussed with the family?

Yes – optional additional notes: _____

No – optional additional notes: _____



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INVESTIGATIONS

IMAGING: RADIOLOGY

- **Imaging results: Diagnosis/Initial Visit**
 - o Ultrasound results [insert attachment]
 - o MRE results [insert attachment]
 - o MRP results [insert attachment]
 - o CT scan [insert attachment]
- **Imaging results: Flare (most recent)**
 - o Ultrasound results [insert attachment]
 - o MRE results [insert attachment]
 - o MRP results [insert attachment]
 - o CT scan [insert attachment]
- **Imaging results: Most recent**
 - o Ultrasound results [insert attachment]
 - o MRE results [insert attachment]
 - o MRP results [insert attachment]
 - o CT scan [insert attachment]

If applicable, bone density [insert attachment]: _____

LABS: PREVIOUS NOTEWORTHY INVESTIGATIONS

- Anti-saccharomyces cerevisiae antibodies (ASCA) and anti-neutrophil cytoplasm antibodies (ANCA) serology: _____
- Measles, Mumps and Rubella (MMR) status: _____
- Thiopurine methyltransferase (TPMT) status: _____
- Viral serologies [insert attachment]
 - o Hepatitis A
 - o Hepatitis B
 - o Hepatitis C
 - o Cytomegalovirus (CMV)
 - o Epstein-Barr Virus (EBV)
 - o Varicella
- Tuberculosis testing results: _____
- IBD-related antibody serology results: _____

LABS: RECENT INVESTIGATION

- Most recent laboratory investigations
- Most recent serum drug titers:
 - o Dose/interval of medication administration: _____
 - o Dose/interval of medication administration: _____
- Fecal calprotectin: _____



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HISTORY OF COMPLICATIONS

HOSPITALIZATIONS

(Please attach hospital discharge summaries for notable hospitalizations)

- Hospitalization #1
 - o Description/reason: _____
 - o Date (MM/DD/YYYY): _____
 - o Clinical course: _____

- Hospitalization #2
 - o Description/reason: _____
 - o Date (MM/DD/YYYY): _____
 - o Clinical course: _____

OTHER COMPLICATIONS

- IBD-related complications: _____
- Non-IBD-related complications: _____

OTHER

FAMILY HISTORY

- Relevant family history (IBD, cancer): _____

IMMUNIZATION HISTORY

- Infectious disease history: _____
- Missing immunizations: _____
- Due to be given: _____

PSYCHOSOCIAL



NOTE: SEND SENSITIVE INFORMATION SEPARATELY OR AS AN ATTACHMENT IF PATIENT CONFIDENTIALITY MAY BE COMPROMISED

- History of mental illness, substance abuse, psychosocial risk factors (sexuality/transgender challenges):

- Current and historic smoking status (including vaping): _____
- Current and historic cannabis use: _____
- Current and historic alcohol use: _____
- Living situation, family conflict: _____
- Post-secondary details/school location: _____
- Long-term life aspirations/goals: _____

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MULTI-DISCIPLINARY TEAM

(Please provide name and contact details. Also, attach consultation reports and most recent clinical report from other specialists involved with the patient's care)

MDT involved in this patient's care:

- Surgeon: _____
- Rheumatologist: _____
- Dermatologist: _____
- Social Worker: _____
- Psychologist/Psychiatrist: _____
- Dietitian: _____
- Other type of provider: _____

CANIBD. Developed May 5, 2022.

Template adapted from: Benchimol EI, et al. Medical Summary Template for the Transfer of Patients with Inflammatory Bowel Disease from Pediatric to Adult Care. J Can Assoc Gastroenterol. 2021;5(1):3-11. doi: 10.1093/jcag/gwab009.

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