



REFERRAL FORM

305 Milner Ave. Suite 920
Scarborough, ON, M1B3V4
P:416.321.3883
F:416.321.5162

focused on prevention, founded on care

REFERRING PHYSICIAN: _____

PATIENT INFORMATION:

NAME: _____
First Last

DOB: _____ M ____ F ____
DD/ MM/ YYYY

OHIP NUMBER _____ VERSION CODE _____

TELEPHONE NUMBER(S): HOME: _____ WORK: _____
MOBILE: _____

(PASTE PATIENT LABEL IF AVAILABLE)

**Please advise patient to bring an interpreter to the appointment if he/she does not understand English well.
This will ensure that informed consent for the procedure can be obtained**

PRESENT COMPLAINT (IF ANY):

PROCEDURE REQUESTED: GASTROSCOPY COLONOSCOPY HEMORRHOID LIGATION

MEDICAL HISTORY:

HISTORY OF	YES	NO
DIABETES		
CAD/ MI		
VALVE REPLACEMENT		
CVA/TIA		
ASTHMA/COPD		
BLEEDING DISORDER		
RECENT JOINT REPLACEMENT(<1 YR)		

MEDICATIONS	YES	NO
ASPIRIN		
TICLID		
PLAVIX		
AGGRENOX		
COUMADIN		

**PLEASE ASK
PATIENT TO
BRING A LIST OF
MEDICATIONS
TO THE
APPOINTMENT**

ALLERGIES: _____

*(If your patient usually receives prophylactic antibiotics e.g. for dental procedures, please note that current guidelines **do not** recommend the use of prophylactic antibiotics for gastroscopy and/or colonoscopy except in patients with complex congenital cardiac abnormalities, mechanical heart valves or recent vascular or joint prosthesis. Such patients are better suited to a hospital setting and we will arrange for this to be done)*

PLEASE INDICATE IF YOU WISH TO HAVE THE PROCEDURE DONE BY A SPECIFIC ENDOSCOPIST
(If not specified, your patient will be assigned to the next available Endoscopist)
Dr. _____

TICK HERE IF CONSULT AND PROCEDURE TO BE DONE SAME DAY

(If consultation and procedure to be done on the same day please ensure patient has a copy of the brochure and preparation instructions and understands the proposed procedure)

Signature of Referring Physician

Billing Number

Date dd / mm/ yyyy

PLEASE FAX REFERRAL REQUEST TO 416- 321-5162