

## REFERRAL FORM

<b>PATIENT INFORMATION</b> (Affix patient label here)  Name: _____ Health Card No.: _____ DOB: _____ Sex:    M    F Tel: _____	<b>REFERRING PHYSICIAN</b>  Name: _____ Billing No.: _____ Telephone No: _____ MD Signature: _____
<input type="checkbox"/> <b>CONSULT</b> <input type="checkbox"/> <b>COLONOSCOPY</b> <input type="checkbox"/> <b>GASTROSCOPY</b> <input type="checkbox"/> <b>ANORECTAL</b> <input type="checkbox"/> <b>CARDIOLOGY</b> <input type="checkbox"/> <b>INTERNAL MEDICINE</b> <input type="checkbox"/> <b>VASECTOMY</b> <input type="checkbox"/> <b>SKIN MINOR SURGERY</b> <i>- Procedure will be carried out at the time of consultation for patients with no medical problems.</i> <i>- Pre-operative internal medicine consultation will be required prior to procedure for patients with significant medical problems to determine risk factors and suitability for undertaking the endoscopic procedure and anesthesia in an out-of-hospital facility.</i> <b>*Please note: We are only able to see patient between 18-84 years of age for endoscopies.</b>	
<input type="checkbox"/> <b>ROUTINE</b> <input type="checkbox"/> <b>URGENT</b> (Please indicate concerns) _____ <b>Reason for Referral?</b> <input type="checkbox"/> Diagnostic for Symptomatic Patients <i>Present Complaints:</i> _____ <input type="checkbox"/> Screening for Colon Cancer	
<b>COLONOSCOPY</b> <input type="checkbox"/> Follow up surveillance <input type="checkbox"/> Date of last colonoscopy _____ <input type="checkbox"/> Family history of colorectal cancer <input type="checkbox"/> History of polyps <input type="checkbox"/> FOBT(+)	<b>GASTROSCOPY</b> <input type="checkbox"/> Anemia <input type="checkbox"/> Nausea <input type="checkbox"/> Dysphagia / Dyspepsia <input type="checkbox"/> GERD <input type="checkbox"/> Abdominal Pain
<b>MEDICAL HISTORY (Must be completed to be considered for direct procedure)</b> <input type="checkbox"/> Angina/MI (please provide latest cardiology consult) <input type="checkbox"/> Renal Failure (please provide CBC, Lytes & Creatinine, Urea etc.) <input type="checkbox"/> Asthma/COPD <input type="checkbox"/> Seizures/Epilepsy <input type="checkbox"/> Atrial Fibrillation/Arrhythmia <input type="checkbox"/> Sleep Apnea <input type="checkbox"/> Bleeding Disorder <input type="checkbox"/> TIA/CVA <input type="checkbox"/> Diabetes <input type="checkbox"/> DM II <input type="checkbox"/> Insulin Dependent <input type="checkbox"/> Other Medical Disorder(s) <input type="checkbox"/> Hypertension	
<b>MEDICATIONS CURRENTLY TAKING</b> <input type="checkbox"/> Aspirin <input type="checkbox"/> Pradaxa <input type="checkbox"/> Coumadin (Warfarin) <input type="checkbox"/> Ticlid <input type="checkbox"/> NSAIDS <input type="checkbox"/> Xarelto (Rivaroxaban) <input type="checkbox"/> Plavix <input type="checkbox"/> Others _____	
<b>Allergies:</b> _____	

**Remarks:** \_\_\_\_\_

**Thank you for your referral.**