GTA Endoscopy Services Referral Form

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

ATTACH PATIENT REPORTS/RESULTS RELATING TO
>PREVIOUS COLON/OGD
> +VE OCCULT BLOOD
>DIAGNOSTIC REPORTS ETC.

Patient must bring an interpreter if he/she does not understand English well to give informed consent for a procedure.

REFERRING PHYSICIAN:_____

PATIENT INFORMATION: (USE LABEL IF AVAILABLE)

NAME: _____
First Last

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

OHIP NUMBER _____**VERSION CODE** _____

TELEPHONE NUMBER(S):

HOME: _____ WORK: _____ CELL _____

PROCEDURE REQUESTED (please check at least one of the following)**:**

GASTROSCOPY □ **COLONOSCOPY** □ **HEMORRHOID LIGATION** □

INDICATION (please check at least one of the following):

ROUTINE SCREENING □ **POSITIVE FIT** □ **POSITIVE FAMILY HISTORY** □ **PREVIOUS POLYPS/CANCER** □

OTHER COMPLAINTS:

_____

_____

ALLERGIES: _____

Medical History	*Yes*	*No*	*Other Medical History*	*Medications*	*Yes*	*No*
Diabetes				*ASPIRIN*		
CAD/MI				*TICLID*		
VALVE REPLACEMENT				*PLAVIX*		
CVA/TIA				*AGGRENOX*		
ASTHMA/COPD				*COUMADIN*		
BLEEDING DISORDER						
RECENT JOINT REPLACEMENT (<1YR)						

*(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

Dr._____

TICK HERE IF CONSULT AND PROCEDURE TO BE DONE SAME DAY □

(If both done same day, please ensure patient has a copy of the brochure, preparation instructions and understands the proposed procedure)

PLEASE FAX REFERRAL REQUEST TO 416- 321-5162

_____ _____ _____

Signature of Referring Physician Billing Number Date dd / mm/ yyyy

YOUR PATIENT HAS BEEN BOOKED FOR A CONSULTATION/COLONOSCOPY/GASTROSCOPY ON _____