

Date: _____

Oakville
Suite 202- 710 Dorval Drive,
Oakville, ON L6K 3V7

Ottawa
2 Gurdwara Road, Suite 100
Nepean, ON K2E 1A2

Refer to a specific physician:

Patient's Name (Last Name / First Name)			Referring Physician	
Patient's Address or Label			Physician's Address or Stamp	
Health Card No. Version:		Gender (circle) Male Female	Physician Referring Number	
Date of Birth mm/dd/yyyy	Daytime Phone	Evening Phone	Physician's Phone No.	Physician's Fax No.
Reason for Consult				
<p>GI Endoscopy evaluation and pre-operative Internal Medicine consultation *Pre-operative Out of Hospital (OHP) requirements for endoscopy As we are an out of hospital premise it is important to engage in a full pre-endoscopy consultation to determine all risk factors and suitability for undertaking the endoscopic procedure and anesthesia in an out of hospital facility</p>				
<input type="checkbox"/> Colonoscopy and Pre-op IM Consult			<input type="checkbox"/> Gastroscopy and Pre-op IM Consult	
Screening Rectal bleeding / FOBT/ FIT positive Family History Abdominal Pain Other:			Abdominal pain; dyspepsia Anemia Other	
Anorectal Problems			Height and Weight	
Abscess/hematoma Fissure Fistula Other:		Rectal Bleeding Hemorrhoids	WEIGHT: HEIGHT:	
Medical History				
Hx of adverse reaction to sedation /anesthesia Diabetes Mellitus: Type I Type II On anticoagulants ASA or Plavix MI / Unstable angina last 6 months			<input type="checkbox"/> Emphysema/Severe COPD <input type="checkbox"/> Ambulatory <input type="checkbox"/> Prosthetic heart valve <input type="checkbox"/> Abnormal renal function <input type="checkbox"/> Other _____	
REFERRALS WILL NOT BE ACCEPTED WITHOUT RECENT CARDIAC IMAGING FOR PATIENTS WITH CARDIAC DISORDERS.				
List all Medications:			Referring Physician Signature:	

We will make 3 attempts to contact the patient. Your patient can call for an appointment 3 business days after referral is sent.

Additional Referral forms Yes No