PES PROVIS ENDOSCOPY SERVICES

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

……

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

☐ Colonoscopy and Pre-op IM Consult	☐ Gastroscopy and Pre-op IM Consult
☐ Screening ☐ Rectal bleeding / FOBT positive ☐ Family History ☐ Abdominal Pain ☐ Other ……	☐ Abdominal pain; dyspepsia ☐ Anemia ☐ Other ……

Anorectal Problems	Height and Weight
☐ Abscess/hematoma ☐ Fissure ☐ Fistula ☐ Hemorrhoids ☐ Rectal Bleeding ☐Other_____	WEIGHT: …… (lbs / kg) HEIGHT: …… (ft / cm)

Medical History

☐ Hx of adverse reaction to sedation /anesthesia	☐ Emphysema/Severe COPD
☐ Diabetes Mellitus: Type I or Type II	☐ Ambulatory
☐ On anticoagulants	☐ Prosthetic heart valve
☐ ASA or Plavix	☐ Abnormal renal function
☐ MI / Unstable angina last 6 months	☐ 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