Canadian Place ENDOSCOPY
LEADERS IN DIGESTIVE HEALTH SCREENING

1065 CANADIAN PLACE UNIT 122-123
Mississauga ONT L4W 0C2
TEL 416-626-2100
FAX 416-620-7874
www.endoscopyclinic.ca

PHYSICIAN REFERRAL FORM

PATIENT NAME:_________________________________ SEX: M F (circle)
(PASTE LABEL IF AVAILABLE)

Address: ______________________________________

OHIP#:____________________Version Code:__________ ______________________________________

DOB:_______________________AGE:________________ ______________________________________

PATIENT CONTACT # ______________________________ **E-MAIL**_______________________________________

REASON FOR REFERRAL

UPPER GI SYMPTOMS	***LOWER GI SYMPTOMS***	***REQUESTING***
❑❑ SURVEILLANCE	❑❑ + FIT	❑❑ COLONOSCOPY
❑❑ FAMILY HISTORY Cancer	❑❑ SCREENING OVER 50	
❑❑ BLOOD IN VOMIT	❑❑ FAMILY HISTORY Cancer	❑❑ GASTROSCOPY
❑❑ WEIGHT LOSS	❑❑ RECTAL BLEEDING	
❑❑ TROUBLE SWALLOWING	❑❑ WEIGHT LOSS	❑❑ SIGMOIDOSCOPY
❑❑ ABDOMINAL PAIN	❑❑ SURVEILLANCE	
	❑❑ CHANGE IN STOOL	

MEDICAL HISTORY

MEDICATIONS	**ALLERGIES**	❑❑ Diabetic (Insulin or Pills)
❑❑ Coumadin	❑❑ LATEX	❑❑ Angina/MI (less than 1 year)
❑❑ Aspirin	❑❑ ANESTHETIC	❑❑ TIA/ CVA
❑❑ Plavix	❑❑ OTHER (LIST)	❑❑ Asthma/COPD
❑❑ Ticlid		❑❑ Continuous Narcotic Use
❑❑ Heparin		❑❑ Morbidly Obese
		❑❑ CPAP/Sleep Apnea

OTHER NOTES:

REFERRING PHYSICIAN:________________________________DATE__________________________
(CAN USE STAMP)

Billing#:_____________________________ **SIGNATURE:**_________________________________

OUR RECEPTIONIST WILL BE HAPPY TO CONTACT YOUR PATIENT WITH APPOINTMENT DATE AND TIME.
THANK YOU FOR YOUR REFERRAL.

FAX TO: 416-620-7874