

**REFERRAL FORM – Fax to 519-254-4158**

**ROSE CITY ENDOSCOPY**

Operated by Dr. V. Khokhotva Medicine  
Professional Corporation  
2109 Ottawa St., Unit 1060, Windsor ON N8Y1R8  
Tel:519-254-4154 [www.rosecityendoscopy.ca](http://www.rosecityendoscopy.ca)

|   |     |    |
|---|-----|----|
| Referral date (dd/mm/yyyy):                 |     |    |
| Is this an urgent referral?                 | YES | NO |
| If yes, specify medical reason for urgency: |     |    |

**Please inform your patient about this referral and give them a copy of our Referral Information sheet**  
**Referral Information sheet provided? YES NO (please see website for information sheet)**  
**Incomplete referrals will be returned**

|  |  |   |  |                                 |     |     |    |
|--|--|---|--|---------------------------------|-----|-----|----|
| Patient Information (affix label or complete Name<br>OHIP# VC<br>DOB (dd/mm/yyyy)<br>Phone<br>Address<br>Email:  |  | Referring MD name:<br><br>Signature:<br><br>OHIP billing#<br>Phone<br>Fax |  |                                 |     |     |    |
| Height (ft) (in) OR (cm)   | Weight (lbs) OR (kg)                                       |   |  |                                 |     |     |    |
| Family MD (mandatory if not the referring provider)  |  |   |  |                                 |     |     |    |
| <b>REASON FOR REFERRAL:</b> Colonoscopy Gastroscopy Flexible Sigmoidoscopy<br>Concise symptoms and provisional diagnosis:  |  |   |  |                                 |     |     |    |
| Previous colonoscopy YES NO Date (mm/yyyy)   |  |   |  |                                 |     |     |    |
| <b>MEDICAL HISTORY</b> (active & relevant past diagnoses)  | Diabetes   |   |  |                                 | YES | NO  |    |
|  | Pacemaker/ defibrillator                                   |   |  |                                 | YES | NO  |    |
|  | Malignant hyperthermia                                     |   |  |                                 | YES | NO  |    |
|  | Myocardial infarction, stroke, DVT/PE in the past 6 months |   |  |                                 | YES | NO  |    |
|  | Neurological disease (Parkinson's/ MS/dementia/other)      |   |  |                                 | YES | NO  |    |
| Home O2/history of intracranial bleeding or aneurysm   |  |   |  | YES                             | NO  |     |    |
| <b>SOCIAL HISTORY:</b>   | Smoker   | YES   | NO   | EtOH                            |     | YES | NO |
|  | Marijuana  | YES   | NO   | History of drug abuse/methadone |     | YES | NO |
| <b>Difficulty with mobility:</b>   | wheelchair/walker  | YES   | NO   | require assistance              | YES | NO  |    |
| <b>CURRENT MEDICATIONS</b> (list ALL current prescription medications; dosing is not required)<br>If the patient is not taking any prescription medications, write NONE. |  |   |  |                                 |     |     |    |
| Medication allergies   | YES  | NO  | List allergies:  |                                 |     |     |    |
| Coumadin/Warfarin  | YES  | NO  | Can it be held for 5 days prior to procedure?              | YES                             | NO  |     |    |
| Plavix, Brilinta, or other systemic antiplatelet Rx  | YES  | NO  | Can it be held for 7 days prior to procedure?              | YES                             | NO  |     |    |
| Direct oral anticoagulant (Dabigatran, Rivaroxaban, Apixaban or similar)   | YES  | NO  | Can anticoagulant be held for 2 days prior to a procedure? | YES                             | NO  |     |    |

**PLEASE NOTE: INCOMPLETE REFERRALS WILL BE RETURNED**