REFERRAL FORM - Fax to 613-354-8241

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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 provide a copy of our referral information sheet Referral information sheet provided? YES NO (See website for information sheet)

REFERRAL REQUEST: GASTROSCOPY COLONOSCOPY OTHER Patient Information (affix label or complete) Referring MD / NP name Name OHIP# Signature VC DOB (dd/mm/yyyy) Phone OHIP billing# Address Phone Fax Family MD (mandatory if not the referring provider) REASON FOR REFERRAL (concise symptoms and provisional diagnosis) If the referral is for a lower GI complaint (including rectal bleeding, hemorrhoidal symptoms, anorectal pain) specify when the last colonoscopy was performed and attach procedure and pathology reports. Previous colonoscopy YES NO Date (mm/yyyy) MEDICAL HISTORY (active & relevant past diagnoses) Diabetes (on medication) YES NO Pacemaker/ defibrillator YES NO Obstructive sleep apnea YES NO Malignant hyperthermia YES NO Myocardial infarction, YES NO stroke, DVT/PE in the past 6 months CURRENT MEDICATIONS (list ALL current prescription medications; dosing is not required) If the patient is not taking any prescription medications, write NONE. Medication allergies YES NO List: Coumadin/Warfarin YES NO Can be held for 5 days before procedure? YES NO YES NO Can be held for 7 days before procedure? YES Plavix, Brilinta, or other NO systemic antiplatelet Rx Direct oral anticoagulant YES NO Can be held for 2 days before procedure? YES NO (Dabigatran, Rivaroxaban Apixaban, and similar)

Please attach additional relevant information (imaging, laboratory results, your office EMR profile, etc.)

PLEASE NOTE: INCOMPLETE REFERRALS WILL BE RETURNED