

Referring Physician: \_\_\_\_\_

Billing Number: \_\_\_\_\_

Physician address: \_\_\_\_\_

Family Doctor (if applicable): \_\_\_\_\_

<p><b>Patient Demographics (full contact info and OHIP #):</b></p>	<p><b>Services Requested:</b></p> <p>Gastroscopy <input type="checkbox"/></p> <p>Colonoscopy <input type="checkbox"/></p> <p>Both Gastroscopy/Colonoscopy <input type="checkbox"/></p> <p>Consultation Only <input type="checkbox"/></p> <p>Urgent <input type="checkbox"/>                      Routine <input type="checkbox"/></p> <p>Seen GI previously (send notes) <input type="checkbox"/></p>
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Reason for Referral:

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Does your patient use any of the following medications (please check box):

- |  |  |   |  |   |
|--|--|---|--|---|
| None <input type="checkbox"/>                  | Warfarin <input type="checkbox"/><br>(Coumadin)  | Aspirin <input type="checkbox"/>                  | Clopidogrel <input type="checkbox"/><br>(Plavix) | Ticagrelor <input type="checkbox"/><br>(Brilinta) |
| Edoxaban <input type="checkbox"/><br>(Lixiana) | Dabigatran <input type="checkbox"/><br>(Pradaxa) | Rivaroxaban <input type="checkbox"/><br>(Xarelto) | Apixiban <input type="checkbox"/><br>(Eliquis)   |   |

Other Medications: \_\_\_\_\_

Does your patient have a known history of:

- |  |                                   |  |  |
|--|-----------------------------------|--|--|
| Angina/MI <input type="checkbox"/>       | Diabetes <input type="checkbox"/> | Bleeding Disorder <input type="checkbox"/> | TIA/CVA <input type="checkbox"/>       |
| Coronary Stent <input type="checkbox"/>  | Asthma <input type="checkbox"/>   | Heart Surgery <input type="checkbox"/>     | Bowel Surgery <input type="checkbox"/> |
| Coronary Bypass <input type="checkbox"/> | COPD <input type="checkbox"/>     | Arrhythmia <input type="checkbox"/>        | Sleep Apnea <input type="checkbox"/>   |
| Kidney disease <input type="checkbox"/>  |                                   |  |  |

Other Medical History: \_\_\_\_\_

Allergies: \_\_\_\_\_

The procedure(s) will be carried out at the time of consultation unless any contraindication exists

*\*Please attach any prior endoscopy/colonoscopy/pathology results with this referral if available*

WE WILL CONTACT YOUR PATIENT DIRECTLY FOR AN APPOINTMENT DATE AND TIME

THANK YOU FOR YOUR REFERRAL

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