CHARLTON DIGESTIVE DISEASE CENTRE

GASTROENTEROLOGY REFERRAL

FAX 289-309-1359

Phone 905-526-7002 ext. 3123 | www.charltonddc.ca

REFERRING PROVIDER

Referring physician / nurse practitioner: _____	OHIP billing no.: _____
Clinic / address: _____	CPSO / CNO no.: _____
Phone: _____ Fax: _____	Referral date: _____
Signature: _____	Preferred report fax: ☐ Same as above

PATIENT INFORMATION

Legal name: _____	Date of birth: ____ / ____ / _____ ☐ M ☐ F ☐ X
OHIP no.: _____ Version: _____	Expiry: ____ / ____ / _____
Address: _____	City / postal code: _____
Primary phone: _____ Alternate: _____	☐ May leave voicemail Preferred language: _____
Family physician (if different): _____	Interpreter / accessibility needs: _____

REQUEST AND CLINICAL INDICATION

SERVICE REQUESTED
☐ Gastroenterology consultation
☐ Hepatology consultation
☐ FibroScan assessment
☐ Gastroscopy
☐ Colonoscopy
☐ Gastroscopy and colonoscopy
☐ Other: _____

PRIORITY
☐ Routine ☐ Urgent - clinical reason required

INDICATION Check all that apply
☐ Positive FIT Date: _____ ☐ Iron-deficiency anemia / low ferritin
☐ Rectal bleeding ☐ Melena
☐ Upper gastrointestinal bleeding ☐ Lower gastrointestinal bleeding
☐ Change in bowel habits ☐ Family history / high-risk screening
☐ Polyp or cancer surveillance ☐ Dysphagia / odynophagia
☐ Reflux / dyspepsia / abdominal pain ☐ Nausea
☐ Vomiting ☐ Unintentional weight loss
☐ Abnormal imaging or laboratory result ☐ Other: _____

Clinical details, duration, red flags and specific question for the gastroenterologist:

_____

_____

MEDICATION AND PROCEDURAL SAFETY INFORMATION

ANTICOAGULANTS / ANTIPLATELETS
☐ None ☐ ASA ☐ Clopidogrel ☐ Ticagrelor
☐ Warfarin ☐ Apixaban ☐ Rivaroxaban
☐ Dabigatran ☐ Edoxaban ☐ Other: _____
Indication / prescriber: _____

OTHER RELEVANT MEDICATIONS
☐ Insulin / diabetes medication
☐ GLP-1 medication Name: _____
☐ Iron ☐ NSAID ☐ Other: _____
Current medication list attached ☐ Yes ☐ No

RELEVANT MEDICAL HISTORY

☐ Cardiac disease / angina / MI	☐ Stent / bypass / valve	☐ Pacemaker / ICD	☐ Arrhythmia
☐ Stroke / TIA	☐ Bleeding disorder	☐ Kidney disease / dialysis	☐ Liver disease
☐ Asthma / COPD / home oxygen	☐ Sleep apnea / CPAP	☐ Diabetes	☐ Prior bowel surgery
☐ Pregnancy possible	☐ Mobility / transfer concern	☐ Prior anesthesia issue	☐ Other: _____

☐ Known or suspected infectious disease - specify: _____

Height: _____ cm Weight: _____ kg BMI: _____ kg/m² ☐ BMI ≥45 kg/m²

Allergies and reactions: _____

Other relevant history: _____

REQUIRED AND HELPFUL ATTACHMENTS

☐ Consultation notes / relevant history	☐ Current medication list	☐ Recent CBC / ferritin / renal function
☐ FIT result / relevant labs	☐ Imaging reports	☐ Prior endoscopy / colonoscopy / pathology

PLEASE FAX THE COMPLETED REFERRAL AND SUPPORTING RECORDS TO 289-309-1359

Charlton Digestive Disease Centre will contact the patient directly. Acceptance, priority and procedure booking are subject to clinical triage.

211 Pritchard Road, Unit 4, Hamilton, ON L8J 0G3 | Entrance located on the right side of the building
CDDC@charltonhealthcare.com | 905-526-7002 ext. 3123 | www.charltonddc.ca