

PHYSICIAN REFERRAL FORM

PATIENT NAME: _____
 (PASTE LABEL IF AVAILABLE)

SEX: M F (circle)

Address: _____

OHIP#: _____ Version Code: _____

DOB: _____ AGE: _____

PATIENT CONTACT # _____ E-MAIL _____

REASON FOR REFERRAL

<i>UPPER GI SYMPTOMS</i>	<i>LOWER GI SYMPTOMS</i>	<i>REQUESTING</i>
<input type="checkbox"/> SURVEILLANCE <input type="checkbox"/> FAMILY HISTORY Cancer <input type="checkbox"/> BLOOD IN VOMIT <input type="checkbox"/> WEIGHT LOSS <input type="checkbox"/> TROUBLE SWALLOWING <input type="checkbox"/> ABDOMINAL PAIN	<input type="checkbox"/> + FOBT <input type="checkbox"/> SCREENING OVER 50 <input type="checkbox"/> FAMILY HISTORY Cancer <input type="checkbox"/> RECTAL BLEEDING <input type="checkbox"/> WEIGHT LOSS <input type="checkbox"/> SURVEILLANCE <input type="checkbox"/> CHANGE IN STOOL	<input type="checkbox"/> COLONOSCOPY <input type="checkbox"/> GASTROSCOPY <input type="checkbox"/> SIGMOIDOSCOPY

MEDICAL HISTORY

MEDICATIONS	ALLERGIES	
<input type="checkbox"/> Coumadin <input type="checkbox"/> Aspirin <input type="checkbox"/> Plavix <input type="checkbox"/> Ticlid <input type="checkbox"/> Heparin	<input type="checkbox"/> LATEX <input type="checkbox"/> ANESTHETIC <input type="checkbox"/> OTHER (LIST)	<input type="checkbox"/> Diabetic (Insulin or Pills) <input type="checkbox"/> Angina/MI (less than 1 year) <input type="checkbox"/> TIA/ CVA <input type="checkbox"/> Asthma/COPD <input type="checkbox"/> Continuous Narcotic Use <input type="checkbox"/> Morbidly Obese <input type="checkbox"/> 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