NORTH YORK ENDOSCOPY

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- All patients must be referred by a physician. -

REFERRAL FORM

Date: .....

Patient 's Name (Last Name / First Name)			Referring Physician	
Patient's Address or Label			Physician's Address or Stamp	
Health Card No.		Gender ☐ Male ☐ Female	Physician Referring Number	
Date of Birth	Daytime Phone	Evening Phone	Physician's Phone No.	Physician's Fax No.

Name of the Doctor for Consult: ☐ DR. G BILBILY (GI) ☐ DR. SALMAN AZIZ (GI) ☐ DR. A MAHARAJ (G.S) ☐ DR. S. SIDDIQUE (G.S) ☐ DR. CLERMONT (GI) ☐ DR. B. KAILA (GI) ☐ DR. M TALWAR (G.S) ☐ DR. A. AL-MAMAR (G.S)

Reason For Referral (please check all that apply) ☐ URGENT ☐ CONSULTATION ☐ FOLLOW UP

GASTROSCOPY ☐	COLONOSCOPY ☐ SIGMOIDOSCOPY ☐	ANORECTAL & OTHERS ☐
☐ ANAEMIA ☐ NAUSEA	☐ HISTORY OF POLYPS ☐ CONSTIPATION	☐ HAEMORRHOIDS ☐ SKIN TAGS / LESIONS
☐ DYSPHAGIA ☐ WEIGHT LOSS	☐ BLOATING / GAS FLATULENCE ☐ DIARRHEA	☐ FISSURE - IN ANO ☐ SEBACEOUS CYST
☐ DYSPEPSIA	☐ RECTAL BLEEDING ☐ ANAEMIA	☐ FISTULA - IN ANO ☐ ANUSITIS
☐ REFLUX SYMPTOMS (GERD)	☐ COLON SCREENING ☐ WEIGHT LOSS	☐ OTHER

EXCLUSION CRITERIA - Check all that apply - (Patients should be referred to hospital based physician):

CARDIOVASCULAR:	☐ Recent MI <6 months OR unstable angina)	☐ CHF	☐ SEVERE VALVULAR HEART DISEASE
PULMONARY:	☐ SEVERE COPD / EMPHYSEMA (ON HOME O2)	☐ SEVERE SLEEP APNEA (CPAP)	☐ MORBID OBESITY (BMI)
GI/LIVER:	☐ BRISK GI BLEEDING / MELENA	☐ DECOMPENSATED LIVER DISEASE	☐ OBSTRUCTIVE JAUNDICE / CHOLANGITIS
OTHER:	☐ CURRENT PREGNANCY	☐ NON-AMBULATORY PATIENT	☐
RENAL:	☐ DIALYSIS PATIENT	☐	☐

MEDICATIONS:

☐ BLOOD THINNERS ☐ ASPIRIN ☐ PLAVIX ☐ WARFARIN / COUMADIN ☐ INSULIN ☐ OTHER:

LIST ALL MEDICATIONS: _____

_____

Medical History

☐ Hx of adverse reaction to sedation /anaesthesia		☐ Patient uses prophylactic antibiotics
☐ Diabetes Mellitus: Type I or Type II		☐ Prosthetic heart valve
☐ Last serum Creatinine	☐ Allergies	☐ Abnormal renal function
☐	☐	☐

Doctor Remarks: _____

Please ask patient to bring interpreter, if does not speak English.	Please indicate if you require additional referral forms ☐	Note: You can also download and print the referral form from our website: **www.nyendoscopycentre.com**
PLEASE FAX or EMAIL THIS FORM TO **Fax: 416-645-1401** **northyorkendoscopyclinic@gmail.com**		Please notify us three (3) business days prior to the appointment date, otherwise a cancellation fee will be applied