# The Toronto GI Clinic

## Patient Referral Form

5 Fairview Mall Dr #450
North York, ON M2J 2Z1

**www.torontogiclinic.com**
**P: 416-322-7517**
**F: 416-489-8053**
**E: tgiclinic@gmail.com**

**Request Specific MD:** ☐ Dr Michael Schiff ☐ Dr Marina Khatchatourian ☐ Dr Stacey Shapira ☐ General Surgery ☐ First Available ☐ Name:_____

**Patient Information (Can Place Label)**

| | |
|---|---|
| Last Name: | First Name: |
| DOB (YYYY/MM/DD): | Gender (please circle): Male Female |
| Health Card: | Address: |
| Email: | |
| Primary Phone: | Secondary Phone: |

**Referring Physician**

| | |
|---|---|
| Name: | Physician Address or Stamp: |
| Billing Number: | |
| Phone: | |
| Fax: | |
| Email: | |

**Reason for Referral:** ☐ *Urgent Referral*

_____

_____

**Type of referral and/or procedure:** ☐ Consult Only ☐ Consult + Procedure ☐ Procedure Only

☐ Urea Breath Test

☐ No Scalpel Vasectomy

☐ Anorectal:
- ☐ Anorectal Bleeding ☐ Anusitis ☐ Fissure ☐ Hemorrhoid ☐ Other:_____

☐ Gastroscopy:
- ☐ Abdominal Pain
- ☐ Anemia
- ☐ Bloating / Gas
- ☐ Dysphagia
- ☐ Heartburn / Reflux
- ☐ Melena
- ☐ Nausea / Vomiting
- ☐ Weight Loss
- ☐ Other:_____

☐ Colonoscopy:
- ☐ Abdominal Pain
- ☐ Anemia
- ☐ Constipation
- ☐ Diarrhea
- ☐ FHx Colorectal Cancer / Polyp
- ☐ Positive FOBT / FIT
- ☐ Rectal bleeding
- ☐ Screening / Surveillance
- ☐ Weight Loss
- ☐ Other:_____

**Medical History:**
- ☐ Asthma / COPD
- ☐ Bleeding Disorder
- ☐ Cardiac Disease
- ☐ Diabetes Mellitus
- ☐ Hypertension
- ☐ Obesity (BMI ≥ 35)
- ☐ Pacemaker
- ☐ Sleep Apnea
- ☐ Other:_____

**Medications:**
- ☐ Anticoagulation:_____
- ☐ ASA / NSAIDs
- ☐ Insulin / Oral hypoglycemics

**PLEASE REFER TO HOSPITAL ENDOSCOPY IF ANY FOLLOWING CRITERIA ARE MET:** AGE < 16, AGE > 85, PREGNANCY, BMI ≥ 45, UNSTABLE HEART DISEASE, SEVERE COPD ON HOME O2, SEVERE LIVER DISEASE, SEVERE KIDNEY DISEASE

**Allergies:**

***Thank you for your referral.***