



The Toronto GI Clinic

Patient Referral Form

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

www.torontogiclinic.com
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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): <input type="checkbox"/> Male <input type="checkbox"/> 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 Melena
 - Anemia Nausea / Vomiting
 - Bloating / Gas Weight Loss
 - Dysphagia Other: _____
 - Heartburn / Reflux
- Colonoscopy:
 - Abdominal Pain Positive FOBT / FIT
 - Anemia Rectal bleeding
 - Constipation Screening / Surveillance
 - Diarrhea Weight Loss
 - FHx Colorectal Cancer / Polyp Other: _____

Medical History:

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

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.