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:_____

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 □ Botox for Anal Fissure □ Lumps and Bumps Surgery

□ Anorectal:

- □ Anorectal Bleeding □ Anusitis □ Fissure □ Fistula □ 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.