NORTH YORK ENDOSCOPY CENTRE

2 Champagne Drive, Unit B19 (Champagne Centre) Toronto, ON M3J 2C5
Tel: 416-645-5145 Fax: 416-645-1401

REFERRAL FORM

Patient Name: _____

Date of Birth: DAY _____ MONTH _____ YEAR _____

Address: _____

Home Phone: _____ Work Phone: _____

Health Card #: _____ Version Code: _____

PLEASE CHECK ALL CONSULTATIONS AND/OR ENDOSCOPY SERVICES REQUESTED:

GASTROENTEROLOGY
- ☐ Dr. G.Y. Bilbily
- ☐ Dr. N. Clermont Dejean
- ☐ Dr. K. Jeejeebhoy
- ☐ Dr. B. Kaila

ENDOSCOPY
- ☐ Gastroscopy
- ☐ Colonoscopy

ANO-RECTAL/GENERAL SURGERY
- ☐ Dr. J. Tan

FOR ENDOSCOPY PATIENTS PROVIDE FOLLOWING INFORMATION:

Anticoagulants ☐ Pacemaker ☐ Arrhythmia ☐
Sleep Apnea ☐ Height_____cm Weight_____lbs
Name of Anticoagulant _____ Dose _____

REASON FOR REFERRAL (Required):

☐ Signs or symptoms (any age, any time, please specify):

_____
_____
_____
_____

- ☐ Screening (age>=50, once every 10 years)
- ☐ Family History (one first degree or two sceond degree relatives with history of colon cancer, once every 5 years)
- ☐ Follow up for one or two adenomas (once every 5 years)
- ☐ Follow up for three or more adenomas (once every 3 years)
- ☐ Follow up for Polyposis syndromes or worrisome polyps (as recommended by previous endoscopy)
- ☐ Incomplete or inadequate colonoscopy
- ☐ Other_____

ATTACH CPP, PREVIOUS LAB TESTS, U/S, CT AND ENDOSCOPY RESULTS (Required)

_____ _____
Print Physician Name Physician Signature

Phone: _____ Fax: _____
(MANDATORY)

Provider #: _____

Additional Copies to: _____