



NORTH YORK ENDOSCOPY

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REFERRAL FORM

Date:

- All patients must be referred by a physician. -

Patient's Name (Last Name / First Name)		Referring Physician		
Patient's Address or Label		Physician's Address or Stamp		
Health Card No.	Gender <input type="checkbox"/> Male <input type="checkbox"/> 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: <input type="checkbox"/> DR. G BILBILY (GI) <input type="checkbox"/> DR. SALMANAZIZ (GI) <input type="checkbox"/> DR. A MAHARAJ (G.S) <input type="checkbox"/> DR. S. SIDDIQUE (G.S) <input type="checkbox"/> DR. CLERMONT (GI) <input type="checkbox"/> DR. B. KAILA (GI) <input type="checkbox"/> DR. M TALWAR (G.S) <input type="checkbox"/> DR. A. AL-MAMAR (G.S)				

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

GASTROSCOPY <input type="checkbox"/>	COLONOSCOPY <input type="checkbox"/>	SIGMOIDOSCOPY <input type="checkbox"/>	ANORECTAL & OTHERS <input type="checkbox"/>
<input type="checkbox"/> ANAEMIA <input type="checkbox"/> NAUSEA <input type="checkbox"/> DYSPHAGIA <input type="checkbox"/> WEIGHT LOSS <input type="checkbox"/> DYSPEPSIA <input type="checkbox"/> REFLUX SYMPTOMS (GERD)	<input type="checkbox"/> HISTORY OF POLYPS <input type="checkbox"/> BLOATING / GAS FLATULENCE <input type="checkbox"/> RECTAL BLEEDING <input type="checkbox"/> COLON SCREENING	<input type="checkbox"/> CONSTIPATION <input type="checkbox"/> DIARRHEA <input type="checkbox"/> ANAEMIA <input type="checkbox"/> WEIGHT LOSS	<input type="checkbox"/> HAEMORRHOIDS <input type="checkbox"/> SKIN TAGS / LESIONS <input type="checkbox"/> FISSURE - IN ANO <input type="checkbox"/> SEBACEOUS CYST <input type="checkbox"/> FISTULA - IN ANO <input type="checkbox"/> ANUSITIS <input type="checkbox"/> 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 <input type="checkbox"/>	Note: You can also download and print the referral form from our website: www.nyendoscopycentre.com
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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
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