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__To be completed by Referring Physician__ - Fax to 416.226.2771**

1. REFERRING Dr. _____ Signature _____ OHIP # _____

Send results to: (Please circle) Referring Doctor / GP / Other

Fax # _____

2. CONSULT ONLY – Please write reason for referral

3. CONSULT AND PROCEDURE – Please indicate reason for referral

Gastroscopy

- ☐ Pain / GERD
- ☐ Dysphagia / Odynophagia
- ☐ Anemia
- ☐ Exclude Celiac
- ☐ Other

Colonoscopy

- ☐ Bleeding
- ☐ Anemia
- ☐ Abdominal Pain
- ☐ Diarrhea
- ☐ Constipation
- ☐ Screening
- ☐ Other

4. PAST MEDICAL HISTORY

- ☐ None
- ☐ Chronic Kidney Disease
- ☐ Diabetes Mellitus
- ☐ Chronic Obstructive Pulmonary Disease
- ☐ Coronary Artery Disease
- ☐ Prior Abdominal/Pelvic Surgery
- ☐ Other

Medications

- ☐ None
- ☐ Coumadin
- ☐ ASA
- ☐ Insulin
- ☐ Plavix
- ☐ Glyburide
- ☐ Prednisone
- ☐ Iron Supplements
- ☐ Other

Allergies

- ☐ None
- ☐ Medications