Referral Request Form

☐ **Richmond Hill** 330 Hwy 7 East, Suite 510, Richmond Hill ON, L4B 3P8 Phone: 905 707-5007, Fax: 905 707 5008
www.digestivehealth.ca

☐ **Pickering** 1031 Brock Rd Pickering ON L1W 3T7
Phone: 905 683 1700, Fax: 905 683 2577
www.villageeastmedical.com

For Office Use Only

Patient Information:

Name:______________________________

Date of Birth______________________________

Patient Phone Number:____________________

OHIP Number:____________________________

Doctor Information:

Referring Physician________________________

Physician Fax No:________________________

Physician Tel No:________________________

Physician Billing No:______________________

Book Directly for Procedure?

☐ **Yes** or ☐ **No** (consultation first)

Reason for Referral? (please check all that apply)

Gastroscopy

- ☐ abdominal pain
- ☐ anemia
- ☐ bloating
- ☐ dysphagia
- ☐ dyspepsia
- ☐ nausea/ vomiting
- ☐ odonophagia
- ☐ reflux symptoms (GERD)
- ☐ weight loss
- ☐ Other (specify)

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Colonoscopy

- ☐ abdominal pain
- ☐ anemia
- ☐ bloating/gas/flatulence
- ☐ blood in stool
- ☐ colon screening (Age 50+)
- ☐ constipation
- ☐ diarrhea
- ☐ history of polyps
- ☐ weight loss
- ☐ family history of colorectal cancer
- ☐ FOBT (+)
- ☐ Following Surveillance
- ☐ Other (specify)

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Consult Services

- ☐ Naturopathic consult
- ☐ Haematology consult (please provide bloodwork)
- ☐ Internal Medicine Consult (please provide bloodwork)
- ☐ Hepatology Consult (please provide blood work)

Lab Services

- ☐ lactose intolerance
- ☐ celiac test
- ☐ urea breath test
- ☐ h. pylori breath test
- ☐ Naturopathic consult
- ☐ Haematology consult (please provide bloodwork)

Medical History (please check ALL and/or attach a CPP)

Height______ Weight______

- ☐ History of heart disease (please provide recent bloodwork, ECG, & latest cardiology consult)
- ☐ CVA/TIA
- ☐ Any Blood Thinners (indicate which one):__________ (please provide recent bloodwork).
- ☐ BMI >35
- ☐ Renal Failure/ Dialysis Patient (please provide CBC, lytes & Creatinine taken within 2 weeks).
- ☐ Diabetes
  - ☐ Insulin Dependant
  - ☐ DM II
- ☐ Lung Disease
  - ☐ Sleep Apnea or on CPAP
  - ☐ COPD
- ☐ Hepatitis A, B, C (circle one)

Medication (Please attach a list if available)

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Allergies

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Three business days cancellation notice required or a $150.00 cancellation fee will apply