Referral Request Form

Digestive Health Clinic
Gastroenterology & Hepatology
www.digestivehealth.ca

RICHMOND HILL:
330 Hwy 7 East, Suite 510, ON, L4B-3P8
Phone: 905-707-5007, Fax: 905-707-5008

PICKERING:
1031 Brock Rd., ON, L1W-3T7
Phone: 905-683-1700, Fax: 905-683-2577

TORONTO:
1246 Yonge St., Unit 300, ON, M4T-1W7
Phone: 416-926-0262, Fax: 416-926-0936

CLEAR FORM

PRINT

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)

_____
_____
_____
_____
_____
_____
_____

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 (+)
- ☐ Follow-up Surveillance
- ☐ Other (specify)

_____
_____
_____

Consult Services

- ☐ Internal Medicine Consult (please provide bloodwork)
- ☐ Hepatology Consult (please provide blood work)
- ☐ Thoracic Surgical Consult

Lab Services

- ☐ Capsule Endoscopy/Colonoscopy
- ☐ Celiac test
- ☐ Urea breath test (H-Pylori test)
- ☐ Lactose intolerance
- ☐ Small Bowel Bacterial Overgrowth (Breath Test)
- ☐ Esophageal Monometry (Richmond Hill Only)
- ☐ Liver Scan (Fibroscan)
- ☐ Fecal Calprotectin

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)

_____
_____
_____
_____

Allergies

_____
_____

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