Toronto Endoscopy Clinic
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Patient Referral Form

Patient Information:

Last Name: _____ First Name: _____

DOB: _____ MM / DD / YYYY HC #: _____ VC: _____

Gender: M ☐ F ☐ Height: _____ Weight: _____

Telephone: _____ Email: _____

Referring MD: _____ Phone: _____

Billing #: _____ Fax: _____

Address: _____

Past Medical History: _____ Medication: _____

Allergies: _____

Reason For Referral (Check all that apply):

Colonoscopy

- ☐ Rectal Bleeding
- ☐ Constipation
- ☐ Diarrhea
- ☐ Screening / Surveillance
  - • Date of Past Procedure: _____
  - • Findings of Past Procedure: _____
- ☐ Positive FOBT / FIT
- ☐ Family History of CRC
- ☐ Abdominal Pain
- ☐ Anemia
- ☐ Weight Loss
- ☐ Other: _____

Gastroscopy

- ☐ Abdominal Pain ☐ GERD
- ☐ Weight Loss ☐ Bloating
- ☐ Nausea / Vomiting ☐ Anemia
- ☐ Family History of Stomach Cancer
- ☐ Dysphagia / Odynophagia
- ☐ Other: _____

Sigmoidoscopy / Anorectal

- ☐ Rectal Bleeding
- ☐ Anorectal Bleeding
- ☐ Assessment for Hemorroids
- ☐ Assessment for Fissures
- ☐ Other: _____

Breath Test & Other

- ☐ SIBO ☐ Fecal Cal
- ☐ Lactose Intolerance
- ☐ Sucrose Intolerance
- ☐ Fructose Intolerance

Consultation Only

Reason for Procedure: _____

Significant Comorbidities (The following will require consultation prior to booking procedures)

- ☐ Insulin - dependent Diabetes
- ☐ Uninvestigated Chest Pain or SOB
- ☐ Anticoagulation: ☐ Warfarin ☐ Clopidogrel / Plavix ☐ Other: _____
- ☐ BMI ≥ 35
- ☐ Bleeding Disorder: _____
- ☐ Personal / Family History of Malignant Hyperthermia
- ☐ Recent URTI
- ☐ Hepatic Impairment
- ☐ Renal Impairment
- ☐ Arrhythmias _____

Exclusion Criteria **(PLEASE REFER TO HOSPITAL BASED SPECIALIST)**

- x CVD: MI/CVA Within 12 Months or Unstable Angina
- x COPD on home O2, or with SOB
- x Symptomatic Valvular Heart Disease
- x Dialysis Dependency
- x Morbid obesity (BMI ≥ 40)
- x Active Pregnancy
- x Age < 18 or Age > 80
- x Decompensated Cirrhosis