

P Patient & Physician Information

Date	Patient Name	Referring Physician		
Health Card No.	Patient Address			
Physician Address				
DOB	Personal Phone	Gender	Male	Female
		Guardian's Phone		

R Reason for Referral

URGENT FOLLOW

Procedure Requested

G GASTROSCOPY

ANEMIA
NAUSEA
DYSPHAGIA
WT LOSS
BLOATING/GAS
DYSPEPSIA
REFLUX

C COLONOSCOPY

ANEMIA
POLYPS HX
CONSTIPATION
DIARRHEA
RECTAL BLEED
FAM H/O
COLON SCRIN

S SIGMOIDOSCOPY

CONSTIPATION
DIARRHEA
RECTAL BLEED
CT FINDINGS
WT LOSS

A ANORECTAL

HEMORRHOIDS
FISSURE
FISTULA
FLATULENCE
OTHERS

E Exclusion Criteria

CV:	PULM:	LIVER:	OTHER:	RENAL:
Recent MI	Severe COPD	GI Bleed	Pregnant	Dialysis
CHF	Sleep Apnea	Liver Disease	Non Ambulatory	
Severe HD	Morbid Obesity	Jaundice		

M Medications

ASPIRIN PLAVIX WARFARIN INSULIN OTHER:

ALL MEDICATIONS:

H Medical History & Comments

Sedation reaction	Prophylactic ABX	Diabetes	Heart valve
Allergies	Creatinine	Interpreter needed	

C Comments

FAX TO: 519-946-3518

Notify 3 business days prior, otherwise cancellation fee applies.