REFERRAL REQUEST FORM

Thornhill Endoscopy Centre

390 Steeles Avenue West, Units 11 & 12, Thornhill, ON L4J 6X2

Tel: (905) 88-COLON (26566) **Fax: (905) 882-6567**

www.thornhillendoscopy.com

Patient Information:	**Referring Physician:**
Patient Name: _____	**Physician Name:** _____
Date of Birth: _____	**Physician Fax #:** _____
Patient Tel #: _____	**Physician Tel #:** _____
Patient OHIP #: _____	**Physician Billing #:** _____

Reason for Referral? (please check all that apply)

Gastroscopy:

☐ Dyspepsia/GERD
☐ Dysphagia/Odynophagia
☐ Nausea/Vomiting
☐ FOBT Positive
☐ Abdominal Pain
☐ Melena
☐ Bloating/Gas
☐ Anemia/Weight Loss

Colonoscopy:

☐ Screening
☐ Family History
☐ History of Polyps
☐ FOBT Positive
☐ Abdominal Pain
☐ Blood in Stool
☐ Constipation/Diarrhea
☐ Anemia/Weight Loss

Ano-Rectal:

☐ Hemorrhoids
☐ Fissure
☐ Fistula
☐ Pilonidal Cyst
☐ Anusitis
☐ Pruritus Ani
☐ Perianal Abscess/Hematoma
☐ Other (specify) _____

Additional Information: _____

_____

_____

_____

Medical History: (please check all that apply)

☐ Hypertension ☐ Angina/MI/PVD ☐ Arrhythmias/CHF/Pacemaker ☐ Smoker

☐ Asthma/COPD ☐ Sleep Apnea ☐ Obesity (BMI≥35) ☐ Diabetes ☐ Hepatic/Renal

☐ TIA/CVA/Seizures ☐ Anesthesia Reaction (Personal **OR** Family History) ☐ Other: _____

Medications: _____

☐ Anti-Coagulants (e.g. Coumadin, Plavix) ☐ ASA/NSAIDs ☐ Insulin

Allergies: _____

THANK YOU FOR YOUR REFERRAL