



Thornhill Endoscopy Centre

REFERRAL REQUEST FORM

390 Steeles Ave W., Thornhill, ON., L4J 6X2, www.thornhillendoscopy.com

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

Patient Information:

Patient Name: _____

Date of Birth: _____

Patient OHIP#: _____

Patient Tel#: _____

Referring Physician:

Physician Name: _____

Physician Fax #: _____

Physician Tel #: _____

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!