BARRIE ENDOSCOPY

5 Quarry Ridge Rd. LL1
Barrie ON L4M 7G1
Ph: 705-797-1112
Fx: 705-797-1113

Referral Form

Referring Physician Information (Please Print)

Referring Physician Name:	Phone Number:	Physician Billing #	Referral Date: (dd/mm/yyyy)

Patient Information (height and weight must be included in referral)

Surname:	Given Name	Date of Birth (dd/mm/yyyy)

Street Address (include apt #)	City	Postal Code

Home Telephone #	Business Telephone #	Health Care (version code)

Height (cm)	Weight (kg)	BMI

Type of Referral (note: patient must be < 75 yr. of age and meet one of the following criteria)

☐ **Colonoscopy** *(asymptomatic pts. only)*	☐ **Gastroscopy**
Reason for Request: ☐ Screening >50 yo ☐ Screening –Positive Family Hx: (describe)_____ _____ ☐ Screening- Previous Polyps/CRC (provide reports if available) ☐ Recall Letter Received Other:	**Reason for Request:** ☐ Uninvestigated Dyspepsia ☐ Reflux: (describe signs and symptoms along with attempted treatment) ☐ Other:_____
Provide Dates of Previous Colonoscopy/Sigmoidoscopy:	**Provide Dates of Previous Gastroscopy:**

Patient Medical History

	Yes	No
Angina/MI/Valvular Dx		
Arrhythmia/Pacemaker/ICD		
TIA/CVA		
Sleep Apnea		
Asthma/COPD		
Bleeding Disorder		
Seizures/Epilepsy		
Insulin Dependent Diabetes		
Renal Impairment (Cr>150)		
Chronic Pain Requiring Opioids		
Morbid Obesity (BMI >35)		

List All Medications:

☐ Coumadin ☐ Plavix ☐ Pradaxa ☐ Xarelto

Allergies:

Other Medical Conditions (Describe):

(Note: Pts must be ambulatory and able to walk 1 flight of stairs unassisted)

Physician Signature:

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