**5 QUARRY RIDGE ROAD, LL 1**

**BARRIE, ONTARIO, L4M 7G1**

**PHONE:705-797-1112**

**FAX: 705-797-1113**

**Barrie, ON L4M 7G1** PHONE: 705-797-1112

FAX: 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)**

|  |  |  |
| --- | --- | --- |
| **Height (cm)** | **Weight (kg)** | BMI |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Surname: | | Given Name | | | Date of Birth (dd/mm/yyyy) |
| Street Address (include apt #) | | | City | | Postal Code |
| Home Telephone # | Business Telephone # | | | Health Care (version code) | |

**Type of Referral** : **PATIENT MUST BE < 75 yr. OF AGE AND MEET ONE OF THE FOLLOWING CRITERIA**

|  |  |
| --- | --- |
| **COLONOSCOPY** | **GASTROSCOPY** |
| **Reason for Request:**  **FIT Positive**  **Positive Family History: Describe\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Previous Polyps, CRC: provide reports if available.**  **Symptomatic: Describe­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | Uninvestigated Dyspepsia  Reflux: (Describe signs and symptoms with attempted treatment)  Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Recall Letter Received \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| **Provide dates of previous colonoscopy:** | Provide dates of previous gastroscopy: |

**THIS SECTION MUST BE COMPLETED**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Patient Medical History** | **Yes** | **No** | **List All Medications:** | |
| Morbid Obesity (BMI >35)**\*** |  |  |
| Sleep Apnea requiring CPAP**\*** |  |  |
| Chronic Opioid Use |  |  |
| Bleeding Disorder**\*** |  |  |
| Angina/MI/Valvular Dx |  |  | **Allergies:**  *Note: Pts must be seizure free for a minimum of 6 months, with no recent medication dosage changes)* | |
| Arrhythmia/Pacemaker/ICD**\*** |  |  |
| Seizures/Epilepsy |  |  |
| TIA/CVA |  |  | **Other Medical Conditions (Describe):**  *(Note: Pts must be ambulatory and able to walk 1 flight of stairs unassisted)* | |
| Insulin Dependent Diabetes**\*** |  |  |
| Family History of Malignant Hyperthermia**\*** |  |  |
| Emphysema/COPD |  |  |
| **\*** Patient should be referred to a specialist directly, must be done at hospital. | | | | |
| **Physician Signature:** | | | | **Date:** |