

MARKHAM ENDOSCOPY REFERRAL FORM

100 Renfrew Drive, Suite 130, Markham ON L3R 9R6 TEL: 905-948-9119 FAX: 905-948-8358

REFERRING PHYSICIAN: _____

PATIENT INFORMATION: (PASTE PATIENT LABEL IF AVAILABLE)

NAME: _____ M _____ F _____
(First) (Last)

DOB: _____ ADDRESS: _____
(day/month/year)

OHIP NUMBER: _____ VERSION CODE _____

TELEPHONE NUMBER(S): HOME: _____ WORK: _____

CELL: _____

MAIN LANGUAGE SPOKEN BY PATIENT: _____

(Please note, if your patient does not speak/read English, he/she should be accompanied by an interpreter at the time of the appointment.)

MEDICAL HISTORY: Weight _____

DOES YOUR PATIENT USE ANY OF THE FOLLOWING MEDICATIONS: (please tick)

COUMADIN (warfarin) _____ ASPIRIN _____ PLAVIX _____ TICLID _____

OTHER MEDICATIONS: (please list)

DOES YOUR PATIENT HAVE ANY HISTORY OF:

ANGINA / MI YES ___ NO ___ DIABETES YES ___ NO ___

Fax Latest Cardiology Consult TIA/CVA YES ___ Date _____ NO ___

ASTHMA YES ___ NO ___ BLEEDING DISORDER YES ___ NO ___

ALLERGIES: (please list) _____

PRESENT COMPLAINT: _____

SERVICE REQUESTED: (please tick) GASTROSCOPY _____ COLONOSCOPY _____

(Please note that the procedure(s) will be carried out at the time of consultation unless any contraindication exists.)

IF AN ABNORMALITY IS FOUND AT ENDOSCOPY REQUIRING FURTHER TREATMENT, DO YOU AUTHORIZE REFERRAL TO ANOTHER PHYSICIAN/FACILITY FOR APPROPRIATE TREATMENT?

YES _____ NO, I WILL ARRANGE THIS MYSELF _____

Signature of Referring Physician _____

Billing Number _____

PLEASE **FAX** TO MARKHAM ENDOSCOPY AT: **905-948-8358**

THANK YOU FOR YOUR REFERRAL

OUR RECEPTIONIST WILL CONTACT YOUR PATIENT RE: APPT DATE AND TIME

Revised: 16/05/2011