PROMED
ENDOSCOPY CLINIC

REFERRAL REQUEST FORM

1315 Finch Ave W #302, North York, ON M3J 2G5, Canada Tel: 416-634-0001 Fax: 416-634-0002 info@promedendoscopy.com Mon- Sat: 8.00am - 4.00pm

PATIENT INFORMATION

Patient name : _____

Date of Birth : ____/____/____ Gender : ☐ Male ☐ Female ☐ Other

Phone Number : _____

Patient Email : _____

OHIP Number : _____

Physician Phone Number : _____

Physician Email : _____

Physician Biling Number : _____

Referring Physician : _____

Physician Fax : _____

REASON FOR REFERRAL

Physician Signature : _____

(Please check all that apply)

Gastroscopy		Colonoscopy/ Flexible Sigmoidoscopy		Ano Rectal
☐ Abdominal Pain	☐ Nausea	☐ Abdominal Pain	☐ Constipation	☐ Hemorrhoids
☐ Anemia	☐ Odonophagia	☐ Anemia	☐ Diarrhea	☐ Fissure- In Ano
☐ Bloating	☐ Reflux Symptoms (GERD)	☐ Bloating/ Gas/Flatulence	☐ History of IBD	☐ Fistula- In Ano
☐ Dysphagia	☐ Weight Loss	☐ Blood in Stool	☐ History of Polyps	☐ Pilondial Cyst
☐ Dyspepsia	☐ Other (please specify)	☐ Colon Screening	☐ Weight Loss	☐ Anusitis

Medical History :

Allergies :

Medications :