

REFERRAL REQUEST FORM



1275 FINCH AVE WEST, Suite 113, TORONTO ON, M3J 0L5
 Tel: (416)-634-0001 Alt. Tel: (416)-635-7670 Fax: (416)-634-0002
 promedendoscopyclinic0@gmail.com
 Mon-Sun: 8.00am - 4.00pm

PATIENT INFORMATION

Patient name : _____ Date of Birth : ___/___/___ Gender : <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other Phone Number : _____ Patient Email : _____ OHIP Number : _____ Height : _____ Weight: _____ Please note BMI > 40 should be referred to hospital	Physician Phone Number : _____ Physician Email : _____ Physician Billing Number : _____ Referring Physician' name : _____ Physician Fax : _____ Physician Signature : _____
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(Please check all that apply)

Gastroscopy	Colonoscopy/ Flexible Sigmoidoscopy/Ano-rectal
<input type="checkbox"/> Abdominal Pain <input type="checkbox"/> Anemia <input type="checkbox"/> Bloating <input type="checkbox"/> Dysphagia <input type="checkbox"/> Dyspepsia <input type="checkbox"/> Nausea <input type="checkbox"/> Odynophagia <input type="checkbox"/> Reflux Symptoms (GERD) <input type="checkbox"/> Weight Loss <input type="checkbox"/> Other (please specify) _____	<input type="checkbox"/> Abdominal Pain <input type="checkbox"/> Anemia <input type="checkbox"/> Bloating/ Gas/Flatulence <input type="checkbox"/> Blood in Stool/ FIT +VE <input type="checkbox"/> Colon Screening <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> History of IBD <input type="checkbox"/> History of Polyps <input type="checkbox"/> Weight Loss <input type="checkbox"/> Hemorrhoid <input type="checkbox"/> Anusitis <input type="checkbox"/> Others (please specify) _____

Medical History

DOES YOUR PATIENT HAVE ANY HISTORY OF:

- | | | |
|--|--|--|
| <input type="checkbox"/> Diabetes Mellitus | <input type="checkbox"/> on Insulin | <input type="checkbox"/> GLP1 Receptor Agonist |
| <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> MI/ Unstable angina last 6 months | |
| <input type="checkbox"/> Abnormal renal function | <input type="checkbox"/> Last serum Cr _____ | |
| <input type="checkbox"/> Asthma / Severe COPD | <input type="checkbox"/> on Puffer | |
| <input type="checkbox"/> Patient uses prophylactic antibiotics | | |
| <input type="checkbox"/> Prosthetic heart valve | | |
| <input type="checkbox"/> Pacemaker | | |
| <input type="checkbox"/> Sleep Apnea | <input type="checkbox"/> on CPAP | |

- | |
|--|
| <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Smoking / Marijuana _____ |
| <input type="checkbox"/> Alcohol _____ |
| <input type="checkbox"/> Operations _____ |
| <input type="checkbox"/> Family History _____ |
| <input type="checkbox"/> Allergies (Please list) _____ |
| <input type="checkbox"/> Anesthesia Complications in past/Risk _____ |
| <input type="checkbox"/> Seizure _____ |

Please send relevant tests or investigations (labs, imaging, recent cardio reports etc)

DOES YOUR PATIENT USE ANY OF THE FOLLOWING MEDICATIONS? (Please check)

- | | | | |
|--|----------------------------------|-----------------------------------|---|
| <input type="checkbox"/> COUMADIN (Warfarin) or LMWH | <input type="checkbox"/> PLAVIX | <input type="checkbox"/> WEGOVY | <input type="checkbox"/> OTHER MEDICATIONS: (Please list all) _____ |
| <input type="checkbox"/> ASPIRIN | <input type="checkbox"/> XARELTO | <input type="checkbox"/> MOUNJARO | |
| <input type="checkbox"/> BRILINTA | <input type="checkbox"/> OZEMPIC | | |

Patient Appointment

PATIENT APPOINTMENT: _____ AT: _____ AM PM

PATIENT INSTRUCTIONS:

***Bring your health card and a list of your medications**

***Please arrange for a responsible adult to accompany you home as you will receive DEEP SEDATION prior to your procedure. You cannot drive for 24 hours or go home alone by taxi.**

***Notify us 3 days prior to your appointment if you need to cancel or reschedule. Patients who fail to show up for their appointment or give insufficient notice of cancellation will be charged \$75.**

***If you are DIABETIC, bring your glucometer & test strips. If you have SLEEP APNEA, bring your machine. If you have ASTHMA, bring your PUFFER. Instructions will be different for patients on Ozempic/mounjaro/wegovy.**

Please ask the front staff for the instructions if you are taking any of the above.

INSTRUCTION FOR GASTROSCOPY

Prior to your appointment: Do not eat for 8 hours and do not drink for 4 hours (including water).

INSTRUCTION FOR COLONOSCOPY

Purchase **BI-PEGLYTE** or **PEGLYTE + 3 DULCOLAX TABLETS** from your pharmacy. They are over-the-counter (if you need prescription please call the clinic).

5 DAYS PRIOR THE PROCEDURE:

1. If you are on **COUMADIN, PRADAXA, PLAVIX, ASPIRIN**, and/or **ORAL IRON** you must confirm with your family doctor or cardiologist if you can stop taking the listed medications 5 days prior to your procedure.

2. Stop eating foods containing **NUTS** or **SEEDS**.

2 NIGHTS PRIOR THE PROCEDURE

• Take **3 BISACODYL** tablets (inside Bipeglyte kit) or **3 DULCOLAX** tablets before bedtime to loosen compacted stool

1 DAY PRIOR THE PROCEDURE

• **NO SOLID FOOD, DAIRY OR SOY PRODUCTS. ONLY CLEAR LIQUIDS** until your procedure is done. You may have water, clear juices (apple, white grape, white cranberry), Gatorade/Powerade (white/yellow/orange), gingerale, 7up, Sprite, and clear tea.

• If you are nauseated, take 1 tablet (50 mg) of Gravol half an hour before taking BI-PEGLYTE or PEGLYTE.

OPTION 1 - BI-PEGLYTE (2 sachets)

MORNING: Mix up the Bipeglyte. Do this by adding the 1st sachet into 1 litre of water. Mix thoroughly. Then, add the 2nd sachet into a second litre of water. Mix thoroughly. Put the 2 litres of solution into the fridge to chill.

• **6:00PM:** Start drinking the 1st litre of **BIPEGLYTE**. Quickly drink a glassful every 10-15 minutes until you have finished the full 1st litre.

• **8:00PM:** Start drinking the 2nd litre of **BIPEGLYTE**. Quickly drink a glassful every 10-15 minutes until you have finished the full 2nd litre. Drink another 2 litres of clear liquids of your choice after you finished the **BIPEGLYTE**.

OPTION 2-PEGLYTE-add 4L of water into the jug.

• From **5:00pm-7:00pm** - drink **2 LITRES** of the solution, 1 glass every 10-15 minutes.

• From **8:00pm-10:00pm** - drink the last **2 LITRES** of the solution, 1 glass every 10-15 minutes. Drink another 1 litre of clear liquids of your choice after you finished the **PEGLYTE**.

IMPORTANT: Stop drinking ALL fluids 4 hours before your procedure time.

COLONOSCOPY INSTRUCTIONS WILL BE DIFFERENT FOR AFTERNOON APPOINTMENTS

DIRECTION:

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