ADVANCE ENDOSCOPY & SPECIALIST CENTER

advanceendoscopy.com

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☐ 786 Blackburn Mews
Kingston, ON. K7P 2N7
Tel: 613.389.7400 • Fax: 613.389.5100

REFERRAL FORM

Date: .....

- All patients must be referred by a physician. -

Patient 's Name (Last Name / First Name)			Referring Physician	
Patient's Address or Label			Physician's Address or Stamp	
Health Card No.		Gender ☐ Male ☐ Female	Physician Referring Number	
Date of Birth	Daytime Phone	Evening Phone	Physician's Phone No.	Physician's Fax No.

EXCLUSION CRITERIA - Check all that apply - (Patients should be referred to hospital based physician):

CARDIOVASCULAR: ☐ Recent MI <6 months OR unstable angina	☐ CHF	☐ SEVERE VALVULAR HEART DISEASE
PULMONARY: ☐ SEVERE COPD / EMPHYSEMA (ON HOME O2)	☐ SEVERE SLEEP APNEA (CPAP)	☐ MORBID OBESITY (BMI)
GI/LIVER: ☐ BRISK GI BLEEDING / MELENA	☐ DECOMPENSATED LIVER DISEASE	☐ OBSTRUCTIVE JAUNDICE / CHOLANGITIS
OTHER: ☐ CURRENT PREGNANCY	☐ NON-AMBULATORY PATIENT	☐ PROSTHETIC HEART VALVE
RENAL: ☐ DIALYSIS PATIENT		

Reason For Referral (please check all that apply) ☐ URGENT ☐ CONSULTATION ☐ FOLLOW UP

GASTROSCOPY ☐	COLONOSCOPY ☐	ANORECTAL & OTHERS ☐
☐ ANAEMIA ☐ NAUSEA	☐ HISTORY OF POLYPS ☐ CONSTIPATION	☐ HAEMORRHOIDS ☐ SKIN TAGS / LESIONS
☐ DYSPHAGIA ☐ WEIGHT LOSS	☐ BLOATING / GAS FLATULENCE ☐ DIARRHEA	☐ FISSURE - IN ANO ☐ SEBACEOUS CYST
☐ DYSPEPSIA	☐ RECTAL BLEEDING ☐ ANAEMIA	☐ FISTULA - IN ANO ☐ ANUSITIS
☐ REFLUX SYMPTOMS (GERD)	☐ COLON SCREENING ☐ WEIGHT LOSS	

Patient's Preference: ☐ MALE PHYSICIAN ☐ FEMALE PHYSICIAN ☐ NO PREFERENCE

NOTE: Kindly include all the relevant reports for patient along with the referral (ECG, bloodwork, etc)

MEDICATIONS:

☐ BLOOD THINNERS ☐ ASPIRIN ☐ PLAVIX ☐ WARFARIN / COUMADIN ☐ INSULIN ☐ OTHER:

LIST ALL MEDICATIONS: _____

Medical History

☐ Hx of adverse reaction to sedation /anaesthesia ☐ Patient uses prophylactic antibiotics

☐ Diabetes Mellitus: Type I or Type II ☐ CVA / TIA

Remarks: _____

_____

Note: Please provide copy of this referral form to the patient and advise the patients to call the relevant clinic location for immediate appointment. Please notify us three (3) business days prior to the appointment date, otherwise a cancellation fee will be applied

Please ask patient to bring interpreter, if does not speak English.	Please indicate if you require additional referral forms ☐	Note: You can also download and print the referral form from our website:

PLEASE FAX or EMAIL THIS FORM TO

☐ Mississauga:	☐ Toronto:	☐ Bowmanville	☐ Kingston
Fax: 905-569-7056	**Fax: 416-463-7008**	**Fax: 905.419.7008**	**Fax: 613.389.5100**
Email: advanceendoscopy@gmail.com	Email: advendo.toronto@gmail.com	Email: advendo.bowmanville@gmail.com	Email: advendo.kingston@gmail.com