GASTROENTEROLOGY REFERRAL REQUEST

Due to the high volume of referrals, routine appointments are being scheduled in 6 to 12 months. Referrals will be reviewed and triaged according to acuity.

DATE (yyyy/mm/dd) __________________

ACUITY □ Routine □ URGENT

REFERRING PHYSICIAN ____________________________

PHYSICIAN SIGNATURE ____________________________

OHIP Billing Number __________________

Phone: ____________________ (ext) ___________ Fax: ____________________

REFERRAL FOR DR: □ David Armstrong □ Eric Greenwald □ Paul Moayyedi □ Bruno Salena
□ Premysl Bercik □ Smita Halder □ Neeraj Narula □ Francis Tse
□ Jihong Chen □ Grigoris Leontiadis □ Ines Pinto-Sanchez □ Ted Xenodemetropoulos
□ Siwar Albashir □ Stephen Collins □ John Marshall □ Marco Puglia □ Mohammad Yaghoobi

Has the patient been previously assessed by a Gastroenterologist (GI) within the last 12 months? □ No □ Yes → Name __________________

Has the patient had a prior GI Endoscopy? □ No □ Yes

Type of Referral: □ New referral □ Re-referral □ 2nd Opinion □ Urgent referral (reason for urgency) __________________________

Reason for Referral: ________________________________________________________

Medical History: ___________________________________________________________

_________________________________________________________________________

_________________________________________________________________________

Current Medications: _________________________________________________________

_________________________________________________________________________

_________________________________________________________________________

_________________________________________________________________________

Abnormal Test Results: _______________________________________________________

_________________________________________________________________________

_________________________________________________________________________

_________________________________________________________________________

Alarm Features
□ Anemia □ Anorexia □ Change in bowel habit □ Dysphagia □ Gl bleeding
□ Jaundice □ Vomiting □ Weight loss

Duration of Symptoms
□ Weeks □ Months □ Years

All referrals MUST be complete and submitted with relevant bloodwork, imaging and endoscopy reports. Please indicate the relevant reports being faxed with this referral: □ Bloodwork □ Imaging □ Endoscopy

Please fax completed referral and accompanying documentation to 905-526-0594

Incomplete referrals WILL NOT BE PROCESSED

If you have any questions about the status of your referral, please contact: 2F2 Digestive Diseases Clinic (905) 521-2100 ext 75353

Confirmation of Appointment Date and Time will be provided via return fax

FOR 2F CLINIC USE ONLY

MUMC ID Number ____________________________

Appointment Date ( yyyy / mm / dd ) ____________________________

Appointment Time (hh : mm) ____________________________

Protocol 1 2 3 4 5 6 Tests Prior: ____________________________

_________________________________________________________________________

OR □ separate requisition attached

Triage MD (print) ____________________________ (signature) ____________________________

Appointment Confirmation Faxed on ( yyyy / mm / dd ) ____________________________

Date ____________________________

Time (hh : mm) ____________________________

By: ____________________________

Print ____________________________

Signature ____________________________

712516 (2020-06)