McMaster University

McMaster University Medical Centre
HAMILTON HEALTH SCIENCES

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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:** _____

Patient's Last Name	First Name	
Address – Street	City	Postal Code
Telephone: ( )		Ext.
Cell Phone: ( )		
Date of Birth (yyyy/mm/dd)	Age	Gender ☐ M ☐ F
HIN	Family Physician	

REFERRAL FOR DR:

☐ Any Physician (next available)	☐ David Armstrong	☐ Eric Greenwald	☐ Paul Moayyedi	☐ Bruno Salena
	☐ Premysl Bercik	☐ Smita Halder	☐ Neeraj Narula	☐ Francis Tse
	☐ Jihong Chen	☐ Grigorios 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: _____

_____ **OR** ☐ Separate List Faxed with Referral

Abnormal Test Results: _____

Alarm Features

- ☐ Anemia
- ☐ Anorexia
- ☐ Change in bowel habit
- ☐ Dysphagia
- ☐ GI 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 <u>WILL NOT BE PROCESSED</u>

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: _____
Appointment Confirmation Faxed on	Date _____ (yyyy / mm / dd)	Time _____ (hh : mm)	By: Print _____ Signature _____	**OR** ☐ separate requisition attached **Triage MD** (print) _____ (signature) _____