ADVANCE ENDOSCOPY & SPECIALIST CENTER
advanceendoscopy.com

2227 South Millway, Suite 303, Mississauga , ON. L5L 3R6
Tel: 905.569.7007 • Fax: 905.569.7056

688 Coxwell Avenue, Suite206, Toronto, ON. M4C 3B7
Tel: 416.463.7007 • Fax: 416.463.7008

222 King Street East, Suite 3100 Bowmanville, ON. L1C 1P6
Tel: 905.419.7007 • Fax: 905.419.7008

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	
RENAL:	☐ DIALYSIS PATIENT		

Reason For Referral (please check all that apply)

☐ URGENT ☐ CONSULTATION ☐ FOLLOW UP

GASTROSCOPY ☐	COLONOSCOPY ☐ SIGMOIDOSCOPY ☐	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	
☐ 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
☐ Diabetes Mellitus: Type I or Type II
☐ Last serum Creatinine ☐ Allergies
☐ Patient uses prophylactic antibiotics
☐ Prosthetic heart valve
☐ Abnormal renal function

Note: Please provide a copy of this referral form to the patient. Please advise the patients to call and fax their relevant clinic for immediate appointment.

Please ask patient to bring interpreter, if patient 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:**
Fax: 905-569-7056
advanceendoscopy@gmail.com

☐ **Toronto:**
Fax: 416-463-7008
advendo.toronto@gmail.com

☐ **Bowmanville:**
Fax: 905-419-7008
advendo.bowmanville@gmail.com

Please notify us three (3) business days prior to the appointment date, otherwise a cancellation fee will be applied