BURLINGTON ENDOSCOPY AND SPECIALIST CENTRE
3155 Harvester Road, Unit 207
Burlington, Ontario L7N 3V2
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burlingtonendoscopy.ca

PATIENT REFERRAL FORM FOR ENDOSCOPY

Test requested	**Patient Identification**
☐ Colonoscopy ☐ Gastroscopy ☐ Gastroscopy + Colonoscopy	Name: DOB: Gender: M F HIN: Address: Patient email: Phone: Alt phone:

Reason for referral

Screening Colonoscopy

- ☐ Average risk screening (no family history)
- ☐ Family history of colon cancer
- ☐ Personal history of colonic adenoma(s)
- ☐ FOBT positive
- ☐ Symptoms (check which apply):
  - ☐ Iron deficiency anemia
  - ☐ Chronic diarrhea (>3 months): negative C. difficile toxin required
  - ☐ Bloody diarrhea
  - ☐ Dysphagia
  - ☐ Weight loss
  - ☐ Abnormal examination or imaging suspicious for cancer

Please provide pertinent result/endoscopy & pathology reports if available to aid triage

Patient Information

Patient not eligible if any of the following:	**Medical Conditions** (Check if apply):	**Blood thinners:**
☐ BMI >35 ☐ Age > 75 ☐ Severe coronary artery disease ☐ Coronary event/PTCA <6 months ☐ Congestive heart failure ☐ ICD/ pacemaker/ mechanical heart valve ☐ Severe COPD ☐on home O_2 ☐ Moderate/severe kidney disease ☐ Cirrhosis ☐ Coagulopathy or platelets <50 ☐ Infection (MRSA/VRE/ESBL/C.difficile)	☐ Diabetes: ☐on insulin ☐ Coronary artery disease ☐ Atrial fibrillation ☐ Asthma/COPD ☐ Sleep apnea ☐ Solitary kidney ☐ Thrombophilia –on anticoagulants ☐ Patient unable to sign consent ☐ Others: ☐ Needs interpreter **Allergies:** _____	☐ ASA ☐ Plavix ☐ Ticagrelor ☐ Warfarin ☐ Apixaban ☐ Eliquis ☐ Xarelto ☐ Other: _____

If patient is not eligible for out of hospital endoscopy, would you like us to arrange for endoscopy in the hospital? ☐Yes ☐No ☐Comment:

Referring provider & billing number:		
Phone:	Fax:	Date: