BURLINGTON ENDOSCOPY AND SPECIALIST CENTRE

3155 Harvester Road, Unit 207
Phone: 905-631-2080 Fax: 905-635-6215

PATIENT REFERRAL FORM

Procedure Requested:	**Name:**
❑ **Gastroscopy**	**DOB:** **Gender:** **M** **F**
❑ **Colonoscopy**	**HIN:**
	Address:
	Patient email:
	Phone: **Alt phone:**

Reason for referral:

- **Average risk screening (no family history)** **Other details:**
- **Family history of colon cancer**
- **Personal history of colonic adenoma(s)**
- **FIT positive**

Symptoms:

- Iron deficiency anemia
- Dysphagia
- Chronic diarrhea (>3 months)
- Bloody diarrhea
- Rectal bleeding
- Weight loss
- Suspicion for GI cancers

Please provide pertinent bloodwork, imaging, endoscopy & pathology reports if available

Patient information:

Not eligible if any of the following:

- BMI >35
- Age > 75
- Severe coronary artery disease
- Coronary event/PTCA <6 months
- Congestive heart failure
- ICD/ pacemaker/ mechanical valve
- Severe COPD on home O_2
- Moderate/severe kidney disease
- Cirrhosis
- Coagulopathy or platelets <50
- Bloodborne/viral infection

Medical Conditions:

- Diabetes: on insulin
- Coronary artery disease
- Atrial fibrillation
- Asthma/COPD
- Sleep apnea
- Solitary kidney
- Thrombophilia
- Others:

Allergies:_____

Blood thinners:

- Clopidogrel
- Ticagrelor
- Warfarin
- Dabigatran
- Rivaroxaban
- Edoxaban
- Other:

Referring Provider: & Billing Number:		
Phone:	Fax:	Date:

For more information, please visit burlingtonendoscopy.ca