ANCASTER ENDOSCOPY CLINIC

Referral Request Form

1144 Wilson St. West, Suite 205
Ancaster, ON L9G 3K9

Tel.: (905) 304-0062
Fax: (905) 304-0058

email: info@ancasterendoscopy.com
www.ancasterendoscopy.com

Patient Name: ______________________

Date of Birth (dd/mm/yyyy): ______________________

Patient Address: ______________________

Patient Tel.: ______________________

OHIP Number: ______________________

Physician Tel.: ______________________

Physician Fax: ______________________

Physician Email: ______________________

Physician Billing Number: ______________________

Referring Physician: ______________________

Reason for referral (please check all that apply)

Physician Signature ______________________

GASTROSCOPY

- ❍ Abdominal Pain
- ❍ Anemia
- ❍ Bloating
- ❍ Dysphagia
- ❍ Dyspepsia
- ❍ Nausea
- ❍ Odonophagia
- ❍ Reflux Symptoms (GERD)
- ❍ Weight Loss
- ❍ Other (please specify) ______________________

COLONOSCOPY

- ❍ Abdominal Pain
- ❍ Anemia
- ❍ Bloating/Gas/Flatulence
- ❍ Blood in Stool
- ❍ Colon Screening
- ❍ Constipation
- ❍ Diarrhea
- ❍ History of IBD
- ❍ History of Polyps
- ❍ Weight Loss
- ❍ IBS

ANO RECTAL

- ❍ Hemorrhoids
- ❍ Fissure - In Ano
- ❍ Fistual - In Ano
- ❍ Pilonidal Cyst
- ❍ Anusitis

Medical History:

Allergies:

Medications:

A 72 hour cancellation notice is required or the patient will be charged for the appointment.