

# Oak Ridges Endoscopy Centre



13291 Yonge Street, Suite 400

Richmond Hill, Ontario L4E 4L6

Phone: 905.751.2930 Fax: 1.866.643.9669

Bloomington Rd.

Yonge St.



King Rd.

Name \_\_\_\_\_

D.O.B. (dd/mm/yyyy) \_\_\_\_\_ Age \_\_\_\_\_ M / F

H.C. \_\_\_\_\_ V.C. \_\_\_\_\_

Phone \_\_\_\_\_ (Alternate) \_\_\_\_\_

## Reason for referral *(check if applies to your patient)*

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Screening colonoscopy     | <input type="checkbox"/> Weight loss    | <input type="checkbox"/> Dyspepsia         |
| <input type="checkbox"/> Family Hx of colon cancer | <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> PUD / H.pylori    |
| <input type="checkbox"/> Familial Polyposis        | <input type="checkbox"/> Melena         | <input type="checkbox"/> Bloating          |
| <input type="checkbox"/> Change of BM              | <input type="checkbox"/> Hematochezia   | <input type="checkbox"/> Nausea / Vomiting |
| <input type="checkbox"/> Anemia                    | <input type="checkbox"/> Positive FOBT  | <input type="checkbox"/> Celiac work-up    |
| <input type="checkbox"/> Other: _____              |   |  |

PMH: HTN / DM / CHF / MI / TIA / STROKE / STENTS / SLEEP APNEA / CABG / CRF /  
A.FIB / PACEMAKER / ART. VALVE / HEP.C / DYSLIPIDEMIA / HEP.B / HIV

If patient has CAD attach recent ECHO / STRESS TEST

Medications: Coumadin / Plavix / Anticoagulants / Insulin / Lasix

Allergies \_\_\_\_\_

Referring MD \_\_\_\_\_ OHIP # \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_