

Level 2 Surgical & Medical Centre 10 Cottrelle Blvd, Ste 207 Brampton, ON L6S 0E2

REFERRAL REQUEST FORM

Phone #: 905-794-4497

Fax #: 905-794-7258

Patient name:				Physician Phone Number:					
Birthday (dd/mm/yyyy):			Physician Email:						
Patient Phone Number:			Physician Billing Number:						
Patient Email:				Referring Physician:					
OHIP Number:				Physician Fax:					
Reason for referral (please check all that apply) Physician Signature:									
Gastroscopy			Colonoscopy				Ano Rectal		
	Abdominal Pain		Nausea		Abdominal Pain		Constipation		Hemorrhoids
	Anemia		Odynophagia		Anemia		Diarrhea		Fissure – In Ano
	Bloating		Reflux Symptoms		Bloating/Gas/		History of		Fistula – In Ano
_			(GERD)		Flatulence		Polyps		
	Dysphagia		Weight Loss		Blood in stool		History of IBD		Pilondial Cyst
	Dyspepsia		Other (please specify)		Colon Screening		Weight Loss		Anusitis
Medical History:									
Allergies: Medications:									
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