



Dynamic Medical Center

Level 2 Surgical & Medical Centre

5734 Yonge St. 3rd Floor,

Toronto, ON M2M 4E7

Phone #: 416-222-5501

Fax #: 416-222-1932

REFERRAL REQUEST FORM

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
<input type="checkbox"/> Abdominal Pain	<input type="checkbox"/> Nausea	<input type="checkbox"/> Abdominal Pain	<input type="checkbox"/> Constipation	<input type="checkbox"/> Hemorrhoids
<input type="checkbox"/> Anemia	<input type="checkbox"/> Odynophagia	<input type="checkbox"/> Anemia	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Fissure – In Ano
<input type="checkbox"/> Bloating	<input type="checkbox"/> Reflux Symptoms (GERD)	<input type="checkbox"/> Bloating/Gas/Flatulence	<input type="checkbox"/> History of Polyps	<input type="checkbox"/> Fistula – In Ano
<input type="checkbox"/> Dysphagia	<input type="checkbox"/> Weight Loss	<input type="checkbox"/> Blood in stool	<input type="checkbox"/> History of IBD	<input type="checkbox"/> Pilonidal Cyst
<input type="checkbox"/> Dyspepsia	<input type="checkbox"/> Other (please specify)	<input type="checkbox"/> Colon Screening	<input type="checkbox"/> Weight Loss	<input type="checkbox"/> Anusitis

Medical History:

Allergies:	Medications:
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A 72-hour cancellation notice is required or the patient will be charged for the appointment