Dynamic Speciality Center
Level 2 Surgical & Medical Centre
45 Hannover Drive, Unit 4,
St. Catharines, ON L2W 1A3

Phone #: 905-684-9999
Fax #: 905-684-9985

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**
☐ Abdominal Pain	☐ Nausea	☐ Abdominal Pain	☐ Constipation	☐ Hemorrhoids
☐ Anemia	☐ Odynophagia	☐ Anemia	☐ Diarrhea	☐ Fissure – In Ano
☐ Bloating	☐ Reflux Symptoms (GERD)	☐ Bloating/Gas/ Flatulence	☐ History of Polyps	☐ Fistula – In Ano
☐ Dysphagia	☐ Weight Loss	☐ Blood in stool	☐ History of IBD	☐ Pilondial Cyst
☐ Dyspepsia	☐ Other (please specify)	☐ Colon Screening	☐ Weight Loss	☐ Anusitis

Medical History:

Allergies:	**Medications:**

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