ADVANCE ENDOSCOPY
& SPECIALIST CENTER
2227 South Millway, Suite 303, Mississauga, ON L5L 3R6
www.advanceendoscopy.com

Tel: 905-569-7007
Fax: 905-569-7056

Date: .....

REFERRAL TO ADVANCE ENDOSCOPY CENTER

- All patients must be referred by a physician. -

Patient 's Name (Last Name / First Name)			Referring Physician	
Patient's Address or Label			Physician's Address or Stamp	
Health Card No. Version:		Gender (pls.circle) Male Female	Physician Referring Number	
Date of Birth	Daytime Phone	Evening Phone	Physician's Phone No.	Physician's Fax No.

Reason For Referral (please check all that apply) ☐ URGENT ☐ ROUTINE

GASTROSCOPY

- ☐ ABDOMINAL PAIN
- ☐ ANEMIA
- ☐ DYSPHAGIA
- ☐ DYSPEPSIA
- ☐ NAUSEA
- ☐ ODYNOPHAGIA
- ☐ REFLUX SYMPTOMS (GERD)
- ☐ WEIGHT LOSS
- ☐ ***OTHER (PLEASE SPECIFY)***

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COLONOSCOPY

- ☐ ABDOMINAL PAIN
- ☐ ANEMIA
- ☐ BLOATING/GAS FLATULENCE
- ☐ BLOOD IN STOOL
- ☐ COLON SCREENING
- ☐ CONSTIPATION
- ☐ DIARRHEA
- ☐ HISTORY OF IBD
- ☐ HISTORY OF POLYPS
- ☐ WEIGHT LOSS

Patient's Preference:

☐ MALE PHYSICIAN ☐ FEMALE PHYSICIAN ☐ NO PREFERENCE

ANORECTAL & OTHERS

- ☐ HAEMORRHOIDS
- ☐ FISSURE - IN ANO
- ☐ FISTULA - IN ANO
- ☐ PILONIDAL CYST
- ☐ ANUSITIS
- ☐ SKIN TAGS/LESIONS

Medical History

- Hx of adverse reaction to sedation /anaesthesia
- Diabetes Mellitus: Type I or Type II
- On anticoagulants?
- MI / Unstable angina last 6 months
- Ambulatory?
- Emphysema/Severe COPD
- Patient uses prophylactic antibiotics
- Prosthetic heart valve
- Abnormal renal function

  Last serum Cr .....

Medications:	Allergies:

Can we have home contact with patient? ☐ Yes ☐ No	Please indicate if you require additional referral forms ☐	Note: You can also download and print the referral form from our website: www.advanceendoscopy.com

PLEASE FAX THIS FORM to 905-569-7056

Please notify us three (3) business days prior to the appointment date, otherwise a cancellation fee will be applied