



GASTROENTEROLOGY (GI) CLINIC REFERRAL FORM

T: 416-323-7543 F: 416-323-7549

Name:
DOB:
HC#:
Phone:
Alt Phone:
Address:

Patient Identification

Referral Physician Expectations:

- Urgent appointment with first available MD
- First available MD
- Specific MD
 - Dr. Stal Dr. Zenlea Dr. Bollegala

Interpreter Required? Yes No

If yes, language required: _____

Name:
Billing No:
Phone:
Fax:
Address:

Referring Physician Information

REASON FOR REFERRAL:

Screening colonoscopy: to assist with triage please provide the following information:

Past medical Hx , Medications, Family Hx Colon CA/polyyps, date of last colonoscopy, personal Hx of colon CA or polyyps (date and type): _____

Symptoms: _____

Has this patient been followed by another gastroenterologist, or undergone an endoscopic procedure in the last 12 months? Yes No

If yes, please elaborate on the need for a second opinion: _____

PLEASE INCLUDE ALL RELEVANT DOCUMENTATION INCLUDING:

gastroscopy, colonoscopy, pathology, radiology reports, and any prior GI notes.

Referring Physician Signature: _____ Date: _____

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PLEASE FAX COMPLETED REFERRAL TO 416-323-7549