WOMEN'S COLLEGE HOSPITAL
Health care for women | REVOLUTIONIZED

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**

Name:
Billing No:
Phone:
Fax:
Address:

Referring Physician Information

Interpreter Required? □ Yes □ No
If yes, language required: _____

REASON FOR REFERRAL:

□ **Screening colonoscopy**: to assist with triage please provide the following information:
Past medical Hx , Medications, Family Hx Colon CA/polyps, date of last colonoscopy, personal Hx of colon CA or polyps (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:** _____

PLEASE FAX COMPLETED REFERRAL TO 416-323-7549