



WOMEN'S COLLEGE HOSPITAL  
Healthcare | REVOLUTIONIZED

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**GASTROENTEROLOGY (GI) CLINIC  
REFERRAL FORM**

**PATIENT INFORMATION**  
(Affix Patient Label/Identification Here)

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
DD/MM/YYYY

Health Card: \_\_\_\_\_ Version Code: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_ Alternate: \_\_\_\_\_

Referral Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  Urgent **Specific Physician?**  Dr. Stal  Dr. Zenlea  Dr. Bollegala  
DD/MM/YYYY  No preference

**ADDITIONAL PATIENT INFORMATION**

Other insurance coverage (IFH, UHIP, other): \_\_\_\_\_  Self-pay

Language spoken: \_\_\_\_\_ Interpreter required:  Yes  No

Allergies: \_\_\_\_\_

Gender: \_\_\_\_\_

**REFERRING PROVIDER INFORMATION**

Name: \_\_\_\_\_ Billing number: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_

Fax: \_\_\_\_\_ Signature: \_\_\_\_\_

Primary Care Provider:  Same

Other (name/contact information): \_\_\_\_\_

**REASON FOR REFERRAL**

Screening/surveillance colonoscopy

Symptoms: \_\_\_\_\_

Fecal Immunochemical Test (FIT +) or Fecal Occult Blood Test (FOBT +): Fax referral to:  
(416) 586-4853 (MSH Colorectal Cancer Diagnostic Assessment Program)  
*Women's College Hospital is participating in a combined program with Mt. Sinai Hospital (MSH) to address FIT+ and FOBT+ patients.*

**FOR ALL CONSULTATIONS PLEASE INCLUDE**

<p><b>Past and current medical history:</b> (Include cumulative patient profile, if available)</p>	<p><input type="checkbox"/> Medication list</p> <p><input type="checkbox"/> Prior GI office notes</p> <p><input type="checkbox"/> All prior scope &amp; path reports; if not available, provide date/findings of outside endoscopies</p>
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**Note: We will expedite 2nd opinion/transfer of care for Inflammatory bowel disease (IBD) only, wait times for non-IBD will be longer.**

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