WCHI
WOMEN'S COLLEGE HOSPITAL
Healthcare | REVOLUTIONIZED

76 Grenville Street, Toronto, Ontario M5S 1B2
Tel: 416-323-7543
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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: ____/____/____
DD/MM/YYYY

❑ **Urgent** **Specific Physician?** ❑ Dr. Stal ❑ Dr. Zenlea ❑ Dr. Bollegala ❑ 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

Past and current medical history: (Include cumulative patient profile, if available)

❑ Medication list
❑ Prior GI office notes
❑ All prior scope & path reports; if not available, provide date/findings of outside endoscopies

Note: We will expedite 2nd opinion/transfer of care for Inflammatory bowel disease (IBD) only, wait times for non-IBD will be longer.