WOMEN'S COLLEGE HOSPITAL
Healthcare | REVOLUTIONIZED
76 Grenville Street
Toronto, Ontario
M5S 1B2

Tel: 416-323-6014 Fax: 416-323-6172

ANORECTAL SURGERY PROGRAM REFERRAL FORM

REFERRAL DATE: ___/___/_____
DD / MM / YYYY

PATIENT INFORMATION
(Affix Patient Label/Identification Here)

MRN:_____ HCN:_____

Name:_____

Sex:_____ Date of Birth:___/___/___
DD / MM / YYYY

Address:_____

Telephone:_____

ADDITIONAL PATIENT INFORMATION

Preferred name: WCH Medical Record Number:

Gender: Pronouns: ❑ He/Him ❑ She/Her ❑ They/Them ❑ Other: _____

Other insurance coverage (IFH, UHIP, etc.): ❑ Self-pay

Language spoken: Interpreter required: ❑ Yes ❑ No

Allergies:

REFERRING PROVIDER INFORMATION

Name:
Address:
Telephone:
Fax:

Billing #: _____

Signature: _____

❑ Referring Provider is not the Primary Care Provider
Primary Care Provider Name: _____
Primary Care Provider Telephone: _____

REASON FOR REFERRAL

☐ Anal fissure _____
☐ Hemorrhoids _____
☐ Perianal fistula _____
☐ Perianal skin tag _____
☐ Pilonidal disease_____

CLINICAL INFORMATION / FINDINGS

Is there a history of inflammatory bowel disease ☐ No ☐ Yes: _____

Has the patient had prior anal surgery ☐ No ☐ Yes: _____

Has the patient had a colonoscopy in the last 2 years (*not required for referral*): ☐ No ☐ Yes

ADDITIONAL INFORMATION

Please attach:
☐ medication list
☐ past medical / surgical history
☐ endoscopy reports