



WOMEN'S COLLEGE HOSPITAL 76 Grenville Street  
 Healthcare | REVOLUTIONIZED 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: _____	Billing #: _____
Address: _____	Signature: _____
Telephone: _____	
Fax: _____	

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: <input type="checkbox"/> medication list <input type="checkbox"/> past medical / surgical history <input type="checkbox"/> endoscopy reports
_____	
_____	

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