



Date: _____

PROVIS RUDD ENDOSCOPY TORONTO CLINIC

123 Edward Street, Ste 400
Toronto, Ontario M5G 1E2
Tel: 416-597-0997 Fax: 416 597 2912

Referred to Specific Physician: _____

Patient's Name (Last Name / First Name)			Referring Physician	
Patient's Address or Label			Physician's Address or Stamp	
Health Card No.		Gender (pls.circle)	Physician Referring Number	
Version:		Male Female		
Date of Birth MM/DD/YYYY	Daytime Phone	Evening Phone	Physician's Phone No.	Physician's Fax No.
Reason for Consult 				
GI Endoscopy evaluation and pre-operative Internal Medicine consultation *Pre-operative Out of Hospital (OHP) requirements for endoscopy As we are an out of hospital premise it is important to engage in a full pre-endoscopy consultation to determine all risk factors and suitability for undertaking the endoscopic procedure and anesthesia in an out of hospital facility.				
☐ Colonoscopy and Pre-op IM Consult ☐ Screening ☐ Rectal bleeding / FOBT positive ☐ Abdominal Pain ☐ Other ☐ Anorectal Problems ☐ Abscess/hematoma ☐ Fissure ☐ Fistula ☐ Hemorrhoids ☐ Rectal Bleeding /OB Positive ☐ Other			☐ Gastroscopy and Pre-op IM Consult ☐ Abdominal pain; dyspepsia ☐ Anemia ☐ Ulcer ☐ Acid Reflux ☐ Gastritis ☐ Celiac Disease ☐ H. Pylori ☐ Crohn's Disease ☐ Difficulty Swallowing ☐ Other Weight...Lbs/Kg BMI	
Medical History ☐ Hx of adverse reaction to sedation /anaesthesia ☐ Diabetes Mellitus: Type I or Type II ☐ On anticoagulants ☐ ASA or Plavix ☐ MI / Unstable angina last 6 months ☐ Emphysema/Severe COPD ☐ Ambulatory ☐ Prosthetic heart valve ☐ Abnormal renal function ☐ Other				
List all Medications:			Referring Physician Signature:	

We will make 3 attempts to contact the patient. Your patient can call for an appointment 3 business days after referral is sent.

Additional Referral forms ☐ Yes ☐ No

Fax to: 416-597-2912