OAKVILLE ENDOSCOPY CENTRE INC.

2125 Wyecroft Road, Unit 5
Oakville, Ontario
L6L 5L7
t: 905.842.3666
f: 905.842.3330

Patient Referral Form

Place Doctor's Office stamp below:

Place Patient Label below:

Dr. _____
Office Name_____

Location_____
Billing # _____
Phone _____
Fax_____

Full Name. _____
(First, Last)

DOB_____ ☐Male ☐Female
Address_____
City, Province, Postal_____
HC #_____
(please indicate if out of province)
Home #_____ Work #_____
Cell #_____

Test Requested: ☐Routine Colon Screening ☐ Repeat Colonoscopy ☐Polypectomy ☐Gastroscopy

OEC Physician: ☐1st Available GI ☐Office Consultation ☐Dr. _____

Doctor's notes (Note: If your patient has a family history of colon cancer, please indicate the age of the family member (s) when diagnosed**):**

_____
_____
_____

In the last six months, has your patient had any surgeries/ gastrointestinal diseases/ or any cardiovascular issues?:

_____
_____

Please indicate if your patient is diabetic: ☐Yes ☐No

✶As a reminder, patients with any of the following, for safety reasons, should be referred to a specific GI's office for an office consultation:

☐> 75 yrs
☐Active Angina within the last 6 months
☐Severe Renal Impairment (Cr>200)
☐Severe Pulmonary Disease (e.g. Home oxygen)
☐Severe Sleep Apnea (CPAP machine)
☐Antiplatelet / Anticoagulant, specify _____
☐ Active C. Diff
☐Prosthetic Heart Valves
☐Experiencing Pain
☐Overt Bleeding
☐BMI > 40

OEC Appt. Date & Time

Dr._____

_____
(M/D/Y)

_____
Time

☐ Pt Notified

☐ Our automated voice message service will notify the patient of their appt. 6 weeks prior to their appt. date