

Additional Referral forms \Box Yes \Box No

Toronto 123 Edw ard Street, Ste 400 Toronto, Ontario M5G 1E2 Tel. 416-597-0997	M5G 1E2 Mississauga, Ontario L5L 1J3		Oakville 710 Dorval Drive, Ste. 202 Oakville, Ontario L6K 3V7 Tel. 905-607-0022	Ottawa 2 Gurdw ara Road, Ste.100 Ottaw a, Ontario K2E 1A2 Tel. 613-216-1823	
Referred to Specific Physician:					
Patient's Name (Last Name / F	ïrstName)		Referring Physician	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 dd/mm/yyyy Daytime	Phone	Evening Phone	Physician's Phone No.	Physician's Fax No.	
Reason for Consult Colonoscopy					
□ 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 List all Medications:			☐ Emphysema/Seve ☐ Ambulatory ☐ Prosthetic heart ve ☐ Abnormal renal fu ☐ Other	□ Emphysema/Severe COPD □ Ambulatory □ Prosthetic heart valve □ Abnormal renal function □ Other Referring Physician Signature:	
We will make 3 attempts to conta	act the patie	ent. Your patient car	n call for an appointment 3 busir	ness days after referral is sent.	

Date: _____

Greater Toronto Area Fax to: 416-597-2912 or 905-607-0013 and for Ottawa Region: 613-216-1824