YES
YORK ENDOSCOPY & SPECIALIST CENTRE

Dr. Hal Laishram F.R.C.S.C

1650 Elgin Mills Road E, Unit 103
Richmond Hill ON L4S 0B2
Tel: (905) 237-0770
Fax: (905) 237-0719

REFERRAL FORM

PATIENT INFORMATION *(place patient label here)*	**REFERRING PHYSICIAN**
Name: _____	Name: _____
OHIP No. _____	Billing No: _____
DOB: _____ M_____F_____	Tel: _____
Tel:	MD Signature:

SERVICES REQUESTED

☐ **Consult** ☐ **Colonoscopy** ☐ **Gastroscopy** ☐ **Vasectomy**

Special Services: ☐ **Cardiology** ☐ **Internal Medicine** ☐ **Minor Procedures (Lumps & Bumps)**

- Procedure will be carried out at the time of consultation for patient with no medical problems.

- Pre-operative internal medicine consultation will be required prior to procedure for patients with significant medical problems to determine risk factors and suitability for undertaking the endoscopic procedure and anesthesia in an out-of-hospital facility.

Please note: We are only able to see patient between 18-84 years of age for endoscopies.

☐ **ROUTINE** ☐ **URGENT (Please indicate concerns)**

Reason for Referral?

☐ Diagnostic for Symptomatic Patients *Present Complaints:*

☐ Screening for Colon Cancer

COLONOSCOPY

☐ Follow up surveillance
☐ Date of last colonscopy?
☐ Family history of colorectal cancer
☐ History of polyps
☐ FOBT(+)

GASTROSCOPY

☐ Anemia
☐ Nausea
☐ Dysphagia / Dyspepsia
☐ GERD
☐ Abdominal Pain

MEDICAL HISTORY (Must be completed to be considered for direct procedure)

☐ Angina/MI *(please provide latest cardiology consult)*
☐ Asthma/COPD
☐ Atrial Fibrillation/Arrhythmia
☐ Bleeding Disorder
☐ Diabetes ☐ Insulin Dependent
☐ Hypertension
☐ Pace Maker/ Automatic Defibillator
☐ Renal Failure *(please provide CBC, Lytes & Creatinine, Urea etc.)*
☐ Seizures/Epilepsy
☐ Sleep Apnea
☐ TIA/CVA
☐ Other Medical Disorder(s) _____

MEDICATIONS CURRENTLY TAKING

☐ Aspirin
☐ Coumadin (Warfarin)
☐ NSAIDS
☐ Plavix
☐ Pradaxa
☐ Ticclid
☐ Xarelto (Rivaroxaban)
☐ Others _____

Allegies: _____

Remarks _____

Thank you for your referral