The Toronto GI Clinic

Patient Referral Form

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Request Specific MD: ☐ Dr Michael Schiff ☐ Dr Marina Khatchatourian ☐ Dr Stacey Shapira ☐ General Surgery ☐ First Available ☐ Name:_____

Patient Information (Can Place Label)

Last Name:	First Name:
DOB (YYYY/MM/DD):	Gender (please circle): Male Female
Health Card:	Address:
Email:	
Primary Phone:	Secondary Phone:

Referring Physician

Name:	Physician Address or Stamp:
Billing Number:	
Phone:	
Fax:	
Email:	

Reason for Referral: ☐ *Urgent Referral*

_____

_____

Type of referral and/or procedure: ☐ Consult Only ☐ Consult + Procedure ☐ Procedure Only

☐ Anorectal:
- ☐ Abscess/Hematoma ☐ Anorectal Bleeding ☐ Anusitis ☐ Fissure ☐ Fistula ☐ Hemorrhoid
- ☐ Pilonidal Cyst ☐ Other:_____

☐ Gastroscopy:
- ☐ Abdominal Pain ☐ Melena
- ☐ Anemia ☐ Nausea / Vomiting
- ☐ Bloating / Gas ☐ Weight Loss
- ☐ Dysphagia ☐ Other:_____
- ☐ Heartburn / Reflux

☐ Colonoscopy:
- ☐ Abdominal Pain ☐ Positive FOBT / FIT
- ☐ Anemia ☐ Rectal bleeding
- ☐ Constipation ☐ Screening / Surveillance
- ☐ Diarrhea ☐ Weight Loss
- ☐ FHx Colorectal Cancer / Polyp ☐ Other:_____

Medical History:
- ☐ Asthma / COPD
- ☐ Bleeding Disorder
- ☐ Cardiac Disease
- ☐ Diabetes Mellitus
- ☐ Hypertension
- ☐ Obesity (BMI ≥ 35)
- ☐ Pacemaker
- ☐ Sleep Apnea
- ☐ Other:_____

Medications:
- ☐ Anticoagulation:_____
- ☐ ASA / NSAIDs
- ☐ Insulin / Oral hypoglycemics

Allergies:

PLEASE REFER TO HOSPITAL ENDOSCOPY IF ANY FOLLOWING CRITERIA ARE MET: AGE < 16, AGE > 85, PREGNANCY, BMI ≥ 45, UNSTABLE HEART DISEASE, SEVERE COPD ON HOME O2, SEVERE LIVER DISEASE, SEVERE KIDNEY DISEASE

Thank you for your referral.