The Toronto GI Clinic

Patient Referral Form

5 Fairview Mall Dr #450
North York, ON M2J 2Z1

www.torontogiclinic.com
P: 416-322-7517
F: 416-489-8053
E: tgiclinic@gmail.com

Request Specific MD:

- ☐ Dr Michael Schiff
- ☐ Dr Stacey Shapira
- ☐ First Available
- ☐ Dr Marina Khatchatourian
- ☐ General Surgery
- ☐ Gastroenterology

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

☐ Urea Breath Test ☐ No Scalpel Vasectomy ☐ Botox for Anal Fissure ☐ Lumps and Bumps Surgery

☐ Anorectal:

- ☐ Anorectal Bleeding ☐ Anusitis ☐ Fissure ☐ Fistula ☐ Hemorrhoid
- ☐ Other:____________________________

☐ Gastroscopy:

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

☐ Colonoscopy:

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

Medical History:

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

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

Medications:

- ☐ Anticoagulation:______________________________
- ☐ ASA / NSAIDs
- ☐ Insulin / Oral hypoglycemics

Allergies:

Thank you for your referral.