Dr. Justina Sam
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Gastroenterology

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PATIENT REFERRAL FORM

Please fax to (416) 222-9238

Thank you for your referral. Our office will contact your patient directly to arrange the appointment.

PATIENT INFORMATION		PHYSICIAN INFORMATION
Name:		Name:
Birthdate:		Address:
Address:		
OHIP#:	Version code:	Billing#:
Home#:		Phone#:
Work/cell#:		Fax#:

REASON FOR REFERRAL:

PROCEDURE (if required):

☐ **COLONOSCOPY**
☐ Screening
☐ Surveillance/history of polyp(s)
☐ Rectal bleeding/FOB+
☐ Family history of colon cancer/polyps
☐ Anemia
☐ Other ______________________________

☐ **GASTROSCOPY**
☐ Dyspepsia
☐ Dysphagia
☐ Reflux
☐ Family history of gastric cancer
☐ Other ______________________________

PAST MEDICAL HISTORY:

☐ Cardiac history (angina, MI, valvular heart disease, pacemaker, __________)
☐ Hypertension
☐ Renal disease
☐ On anticoagulation/Plavix/Ticlid

☐ TIA/stroke
☐ Diabetes
☐ COPD/asthma/sleep apnea
☐ Other ______________________________

MEDICATIONS:

ALLERGIES:

Please attach any relevant bloodwork, imaging, endoscopy reports and fax to: (416) 222-9238.