	NORTH SCARBOROUGH ENDOSCOPY CLINIC **ENDOSCOPY REFERRAL FORM** 4040 Finch Av East #105 Scarborough M1S4V5 Telephone: 416.293.9402 Fax: 416.293.7470

Patient's Last Name / First Name		Referring MD/NP	
Patient Address or Label		Address or Stamp	
Health Card	DOB Sex	OHIP Referral Number	
Phone	Email	Phone	Fax

Reasons for Referral

COLONOSCOPY

- ☐ Screening Age > 50
- ☐ FIT Positive or Anemia
- ☐ Family History
- ☐ Symptoms
- ☐ Other:

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GASTROSCOPY

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

SIGMOIDOSCOPY

- ☐ Bleeding Pain Prolapse

Medical History; NB: Patients with comorbidities, risk factors and age > 80 may need hospital setting

- ☐ Diabetes
- ☐ Anticoagulation
- ☐ MI Angina PCI -recent
- ☐ Obesity
- ☐ COPD Asthma
- ☐ Prosthetic Valve
- ☐ Renal failure
- ☐ Sleep Apnea
- ☐ Anesthetic reaction
- ☐ Other ______________________________

Medications:

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Allergies:

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