

**FULLY COMPLETE & FAX TO:  
416-603-6204**

**Referral date:** \_\_\_\_\_  
(dd-mm-yyyy)

PATIENT LAST NAME:		PATIENT FIRST NAME:	
HEALTH CARD #:	VER CODE:	DATE OF BIRTH (DD-MM-YYYY):	
<input type="checkbox"/> SELF PAY		<input type="checkbox"/> OUT OF PROV: _____	
SEX ON HEALTH CARD: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> X	GENDER:	<input type="checkbox"/> Interpreter Required Language spoken:	
ADDRESS:		PRIMARY PHONE #:	
CITY:	PROV:	POSTAL CODE:	SECONDARY PHONE #:

<b>SPECIALITY CLINIC:</b>		<b><u>SYMPTOMS:</u></b> <input type="checkbox"/> Anemia <input type="checkbox"/> Dysphagia <input type="checkbox"/> GI bleeding <input type="checkbox"/> Vomiting <input type="checkbox"/> Abnormal physical exam <input type="checkbox"/> Abnormal imaging study <input type="checkbox"/> Significant weight loss
<input type="checkbox"/> <b>Nutrition Clinic</b> Use referral form: <a href="https://www.uhn.ca/UHNReferrals/Nutrition-Clinic-Referral-Form.pdf">https://www.uhn.ca/UHNReferrals/Nutrition-Clinic-Referral-Form.pdf</a>	<input type="checkbox"/> <b>Inflammatory Bowel Disease Clinic</b> Use Referral Form: <a href="https://www.uhn.ca/UHNReferrals/IBD-TWH-Referral-Form.pdf">https://www.uhn.ca/UHNReferrals/IBD-TWH-Referral-Form.pdf</a>	
<b>Centralized FIT Referral Program</b> <input type="checkbox"/> <b><u>MUST</u></b> attach copy of positive FIT result	<input type="checkbox"/> <b>Capsule Endoscopy</b> Use referral form: <a href="https://www.uhn.ca/UHNReferrals/Small_Bowel_Wireless_Capsule_Endoscopy_Referral_Form.pdf">https://www.uhn.ca/UHNReferrals/Small_Bowel_Wireless_Capsule_Endoscopy_Referral_Form.pdf</a>	
Has the patient been assessed by a Gastroenterologist in the past 48 months? <input type="checkbox"/> NO <input type="checkbox"/> YES → Name: _____		
<b>ATTACH ALL RELEVANT INFORMATION</b>		<b><u>DURATION OF SYMPTOMS:</u></b> <input type="checkbox"/> Weeks <input type="checkbox"/> Months <input type="checkbox"/> Years
<input type="checkbox"/> Current Medication & Allergy List <input type="checkbox"/> Past Medical & Surgical History <input type="checkbox"/> Endoscopic & Imaging Reports <input type="checkbox"/> Laboratory and Pathology reports		
<b>REFERRING PROVIDER</b>		
NAME:		OHIP BILLING #:
PHONE #:	FAX #:	
ADDRESS:	CITY:	PROV: POSTAL CODE:
<b>ADDITIONAL COMMENTS FOR REFERRAL:</b>		