Gut Check Clinic	**REFERRAL FORM**	**OFFICE - 905-948-9119** **FAX - 905-948-9119**	We have several convenient locations to serve your patients needs

PATIENT INFORMATION

NAME: _____
(LAST) (FIRST)

SEX: ❑ M ❑ F OHIP: _____ | | | (Version Code) DOB: ____/____/____ DD MM YYYY

ADDRESS: _____

DAYTIME NUMBER: ( ) _____ CELL NUMBER: ( ) _____

EMAIL ADDRESS: _____

Please Note: If your patient does not speak/read English, he/she should be accompanied by an interpreter at the time of the appointment.

MAIN LANGUAGE SPOKEN BY PATIENT: _____

MEDICAL HISTORY

HEIGHT: _____(cm/ft) WEIGHT: _____(kg/lbs) BMI: _____

HIGH BLOOD PRESSURE	❑ YES	❑ NO	SEIZURES/EPILEPSY	❑ YES	❑ NO
BLEEDING DISORDER	❑ YES	❑ NO	ASTHMA/COPD	❑ YES	❑ NO
ANGINA/MI	❑ YES	❑ NO	SLEEP APNEA/SNORTING	❑ YES	❑ NO
Please Fax Latest Cardiology Consult If available.			EXCESSIVE DAYTIME SLEEPINESS	❑ YES	❑ NO
TIA/CVA/ATRIAL FIB. (YR:_____)	❑ YES	❑ NO	OTHER MEDICAL/SURGICAL	_____	
DIABETES	❑ YES	❑ NO	_____		

ALLERGIES: _____

MEDICATION(S): ❑ COUMADIN (WARFARIN) ❑ ASPIRIN ❑ PLAVIX ❑ TICLID
❑ XARELTO (RIVAROXABAN) ❑ PRADAXA ❑ OTHERS: _____

_____

SERVICE REQUESTED

❑ GASTROSCOPY ❑ COLONOSCOPY

Please Note: Procedure(s) will be carried out at the time of consultation unless any contraindication exists.

PRESENT COMPLAINT: _____

_____

IF ANY ABNORMALITY IS FOUND AT ENDOSCOPY REQUIRING FURTHER TREATMENT,
DO YOU AUTHORIZE REFERRAL TO ANOTHER PHYSICIAN/FACILITY FOR APPROPRIATE TREATMENT?

❑ YES ❑ NO, I WILL ARRANGE THIS MYSELF

REQUESTING PHYSICIAN

PHYSICIAN NAME: _____ BILLING NUMBER: _____

PHYSICIAN SIGNATURE: _____ DATE: _____
(DD / MM / YYYY)

FOR ANY QUESTIONS PLEASE CALL OUR OFFICE: 905-948-9119 **PLEASE FAX** TO ATLAS ENDOSCOPY (formerly Woodbine): **905-948-8358**
WE WILL CONTACT YOUR PATIENT TO BOOK PPOINTMENT. THANKS FOR YOUR REFERRAL