EMAIL: info@gutcheckclinic.com

OFFICE: 416-906-7067
FAX: 905-948-9119

GutCheck Clinic Referral Form

PATIENT INFORMATION

NAME: ____
(LAST) (FIRST)

SEX: ❒ M ❒ F OHIP: ______________________ DOB:_____/_____/_____
(Version Code) DD MM YYYY

ADDRESS: ______________________________

DAYTIME NUMBER: (___) ____________________ CELL NUMBER: (___) ____________________

EMAIL ADDRESS: ______________________________

MAIN LANGUAGE SPOKEN BY PATIENT: ____________________

MEDICAL HISTORY

HEIGHT: ______________ (cm/ft) WEIGHT: ____________________ (kg/lbs)

HIGH BLOOD PRESSURE	❒ YES ❒ NO	SEIZURES/EPILEPSY	❒ YES ❒ NO
BLEEDING DISORDER	❒ YES ❒ NO	ASTHMA/COPD	❒ YES ❒ NO
ANGINA/MI	❒ YES ❒ NO	SLEEP APNEA/SNORING	❒ YES ❒ NO
TIA/CVA/ATRIAL FIB. (YR:______)	❒ YES ❒ NO	OTHER MEDICAL/SURGICAL	________________
DIABETES	❒ YES ❒ NO		

ALLERGIES: ____

MEDICATIONS: ____

GI Issues of Concern:

❒ Dysphagia	❒ Lower Abdominal Pain
❒ GERD	❒ Chronic Tenesmus/Diarrhea
❒ Abdominal Bloating/Distention/Gas	❒ Chronic Constipation
❒ Upper Abdominal Pain	❒ Rectal Bleeding/ Hemorrhoids

Specialized Areas of Concern:

- ❒ Irritable Bowel Syndrome -- Mostly constipation
- ❒ Irritable Bowel Syndrome -- Mostly diarrhea
- ❒ Food Allergies/Intolerances Celiac Disease
- ❒ Other Concerns (please specify) →

REQUESTING PHYSICIAN

PHYSICIAN NAME ____________________ BILLING NUMBER: ______________

PHYSICIAN SIGNATURE ____________________ DATE: ____________________

FOR ANY QUESTIONS ***PLEASE Email us or send referral to: info@gutcheckclinic.com***