



Referring Physician: _____

Address: _____
(Street Number, Name & Suite) (City/Province) (Postal Code)

Billing Number: _____ Fax #: _____ Phone #: _____

Patient Demographics: **(ALL FIELDS MUST BE COMPLETED FOR THE REFERRAL TO BE ACCEPTED)**

NAME: _____ Height: _____ Weight: _____ BMI: _____
(Last) (First) ***** If BMI is 40 and over - refer to hospital**

DOB (MM/DD/YY): _____ *****If age 75 or over - refer to hospital** OHIP: _____ VC: _____

ADDRESS: _____
(Street Number, Name & Suite) (City/Province) (Postal Code)

TELEPHONE: Home _____

EMAIL: _____

INTERPRETER REQUIRED: Yes _____ Language _____

*****Note - we do not schedule or provide interpreter services**

Medical Information:

Does your patient use any of the following medications? **Please attach the patient's CPP with referral.**

- Coumadin (Warfarin) Apixaban Plavix Ticlid Pradax Xarelto Clopidogrel
 Ticagrelor Rivaroxaban Iron Other Medications, Please list, or attach a list

Does your patient have any history of: Use a Puffer Use Nitro spray CHF Ahythmia

- Angina/MI Asthma COPD Diabetes TIA/CVA Bleeding Disorder Arthritis
 Obstructive Sleep Apnea Allergies: _____

If patient has cardiac history – Please attach report.

For patient with anemia – Please attach last lab report and consider both colonoscopy and gastroscopy. If positive FOBT – Please attach report.

Service Requested: URGENT Yes No

Gastroscopy Colonoscopy Both

Previous Colonoscopy: Yes No if yes, send report of last Colonoscopy/Gastroscopy

Please Note: Procedure(s) will be carried out at the time of consultation unless any contraindications exist

Presenting Complaint: _____

Physician Signature: _____ Referral Date _____

Please FAX this form to London Scoping Centre - London at 519-433-4702 WE WILL CONTACT YOUR PATIENT DIRECTLY TO CONFIRM AN APPOINTMENT DATE AND TIME

Thank you for your Referral.