Holly Endoscopy Clinic

40 Holly Street, Suite 301
Toronto, Ontario M4S 3C3

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Patient Referral Form (PLEASE FILL OUT AND FAX TO HOLLY ENDOSCOPY AT **416-486-7888**)

Thank you for your referral. Your patient will be contacted within 3 business days to arrange the appointment.

Last name: First name: Sex: M / F

Date of birth: DD / MM / YYYY Age: Height: Weight: BMI:

Home address:

City: Postal code:

Email:

Telephone #: Cell #: Work #:

Health card: **Version code:**

Emergency contact: Telephone #:

REASON FOR REFERRAL (PLEASE PRINT)

☐ Consultation Only *(please describe)*

PROCEDURE (PLEASE PRINT)

☐ COLONOSCOPY

☐ Sedation* ☐ No Sedation

☐ Screening ☐ Rectal Bleeding / OB positive

☐ Anorectal problems (please describe)

☐ GASTROSCOPY

☐ Sedation* ☐ No Sedation

☐ Abdominal pain, dyspepsia

☐ Anemia

MEDICAL HISTORY (PLEASE PRINT)

Previous Colonoscopy? ☐ No ☐ Yes (*If **Yes**, please provide date*) DD / MM / YYYY

Does your patient use any of the following medications:

☐ Coumadin (warfarin) ☐ Aspirin ☐ Plavix ☐ Ticlid

Other medications (please list):

Does your patient have any history of:

☐ Angina / ML ☐ TIA / CVA ☐ Diabetes ☐ Asthma ☐ Sleep Apnea ☐ Bleeding Disorder

☐ Allergies (please list) ☐ Pacemaker

Previous exposure to:

☐ MRSA ☐ VRE ☐ C.difficile

If your patient normally receives prophylactic antibiotics, e.g., for dental procedures, please note that current guidelines do not recommend the use of prophylactic antibiotics for gastroscopy and/or colonoscopy except in patients with complex cardiac abnormalities or mechanical heart valves.

REFERRING PHYSICIAN (PLEASE PRINT)

Referring Physician Name Billing Number

Signature of Referring Physician

PHYSICIAN STAMP

HSEC(MAR-2017) Refferal Form