NSEC North Scarborough Endoscopy Clinic

North Scarborough Endoscopy Clinic
105-4040 Finch Ave E
Scarborough, Ontario M1S 4V5
Tel 416-293-9402 Fax 416-293-7470

ENDOSCOPY REFERRAL

Date: _____

Patient's Name (Last Name / First Name)		Referring Physician	
Patient's Address (or Label)		Physician's Address (or Stamp)	
Health Card No.	Date of Birth Male Female	Physician Referring Number	
Daytime Phone	Evening Phone	Physician's Phone No.	Physician's Fax No.

Reasons for Referral

- ☐ Colonoscopy
  - ☐ Screening - age >50
  - ☐ FOBT **Positive** / Rectal Bleeding
  - ☐ Screening - family history
  - ☐ Symtoms
  - ☐ Others
- ☐ Gastroscopy
  - ☐ Abdominal pain; dyspepsia
  - ☐ Anemia
  - ☐ Other

_____ _____

Medical History

- ☐ Hx of adverse reaction to sedation / anesthesia
- ☐ Diabetes Mellitus: Type 1 or Type 2
- ☐ On anticoagulants?
- ☐ MI / Unstable angina last 6 months
- ☐ Morbid Obesity?
- ☐ Other significant medical or surgical history _____
- ☐ Emphysema / Severe COPD
- ☐ Patient uses prophylactic antibiotics
- ☐ Prosthetic heart valve
- ☐ Abnormal renal function
  Last serum Cr _____
- ☐ Sleep Apnea

NB: Patients with significant comorbidities / risk factors may be booked to have their procedure in a hospital setting

Medications:	Allergies:

If you would like patient to see a specific doctor

- ☐ Dr. Gerald Chan
- ☐ Dr. Eric Hurowitz
- ☐ Dr. Vincent Thien
- ☐ Next available endoscopist
- ☐ Dr. Timothy Devlin
- ☐ Dr. Winnie Leung
- ☐ Dr. Patrick Yau

Please fax this form to 416-293-7470