



**Dynamic Medical Center**

Level 2 Surgical & Medical Centre

5734 Yonge St. 3<sup>rd</sup> Floor,

Toronto, ON M2M 4E7

Phone #: 416-222-5501

Fax #: 416-222-1932

**REFERRAL REQUEST FORM**

<b>Patient name:</b> _____	<b>Physician Phone Number:</b> _____
<b>Birthday (dd/mm/yyyy):</b> _____	<b>Physician Email:</b> _____
<b>Patient Phone Number:</b> _____	<b>Physician Billing Number:</b> _____
<b>Patient Email:</b> _____	<b>Referring Physician:</b> _____
<b>OHIP Number:</b> _____	<b>Physician Fax:</b> _____

**Reason for referral (please check all that apply)**

**Physician Signature:** \_\_\_\_\_

Gastroscopy		Colonoscopy		Ano Rectal
<input type="checkbox"/> Abdominal Pain	<input type="checkbox"/> Nausea	<input type="checkbox"/> Abdominal Pain	<input type="checkbox"/> Constipation	<input type="checkbox"/> Hemorrhoids
<input type="checkbox"/> Anemia	<input type="checkbox"/> Odynophagia	<input type="checkbox"/> Anemia	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Fissure – In Ano
<input type="checkbox"/> Bloating	<input type="checkbox"/> Reflux Symptoms (GERD)	<input type="checkbox"/> Bloating/Gas/Flatulence	<input type="checkbox"/> History of Polyps	<input type="checkbox"/> Fistula – In Ano
<input type="checkbox"/> Dysphagia	<input type="checkbox"/> Weight Loss	<input type="checkbox"/> Blood in stool	<input type="checkbox"/> History of IBD	<input type="checkbox"/> Pilonidal Cyst
<input type="checkbox"/> Dyspepsia	<input type="checkbox"/> Other (please specify)	<input type="checkbox"/> Colon Screening	<input type="checkbox"/> Weight Loss	<input type="checkbox"/> Anusitis

**Medical History:**

  
  
  
  
  
  
  
  
  
  

<b>Allergies:</b>	<b>Medications:</b>
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A 72-hour cancellation notice is required or the patient will be charged for the appointment