KENSINGTON SCREENING CLINIC
REFERRAL FORM

340 COLLEGE STREET, SUITE 601, TORONTO, ONTARIO, M5T 3A9, PH: 416-928-9511, FX: 416-928-9513

REFERRING PHYSICIAN INFORMATION

Referring Physician:	Referral Date:
Office Phone Number:	Office Fax:
Office Contact Person:	

Referring to Dr. Or First Available Appointment / Endoscopist: ☐

PATIENT INFORMATION

Patient Name: first name middle name last name | Health Card No:

Gender: ☐ Male ☐ Female | DOB: | *Height: _____ ☐ ft ☐ cm | *Weight: _____ ☐ lbs ☐ kg

Address:

Cell Phone No: | Home Phone No:

Patient Speaks : ☐ English ☐ French ☐ Portuguese ☐ Spanish ☐ Mandarin ☐ Cantonese ☐ Korean ☐ Other: _____.

NOTE: if your patient is unable to read or speak English they MUST be accompanied by an Interpreter.

REASON FOR REFERRAL

☐ COLONOSCOPY ☐ GASTROSCOPY (EGD) ☐ COLONSCOPY AND EGD

SYMPTOMS:

☐ + FOBT. DATE: | ☐ Family Hx of ☐ Polyps or ☐ Colon Cancer. DATE:

☐ RECTAL BLEEDING. DATE of Onset: | ☐ IBD | ☐ GERD | ☐ DYSPEPSIA | ☐ DYSPHAGIA

☐ OTHER:

_____

_____

_____

***MEDICAL HISTORY**

Note: If there is any CARDIAC HISTORY copies of the most recent cardiac assessments MUST accompany this referral request. Failure to include these notes may result in cancellation of the procedure for safety reasons.

☐ Angina ☐ MI Date:	☐ A-FIB/FLUTTER ☐ Previous DVT/PE	☐ ASTHMA
☐ COPD/COLD	☐ CVA/ TIA Date:	☐ Diabetes Type ☐ I ☐ II Dx Date:
☐ Bleeding disorder: _____	☐ On ANTICOAGULANTS Name of Treatment: _____	☐ Previous reaction to Anaesthesia ☐ Malignant Hyperthermia Date:
Other:		☐ None

If any abnormality is found at Endoscopy requiring further treatment, do you authorize referral to another physician/centre for treatment?
☐ Yes ☐ No, I will arrange myself.

Referring MD Signature: _____ | **Date:**

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