Kensington HEALTH

340 COLLEGE ST, SUITE 601, TORONTO, ONTARIO, M5T 3A9 | PHONE: 416-928-9511 | FAX: 416-928-9513 | www.kensingtonhealth.org/screening-clinic

KENSINGTON SCREENING CLINIC REFERRAL FORM

REFERRING PHYSICIAN INFORMATION

REFERRING PHYSICIAN: | REFERRAL DATE:

PHONE #: | FAX #: | OFFICE CONTACT:

REFERRING TO DOCTOR: | OR FIRST AVAILABLE APPOINTMENT/ ENDOSCOPIST ☐

PATIENT INFORMATION

FULL NAME (INCLUDING MIDDLE):

GENDER: ☐ MALE ☐ FEMALE ☐ NONE | D.O.B:

ADDRESS:

HOME PHONE #: | CELL PHONE #:

PATIENT SPEAKS: ☐ ENGLISH ☐ FRENCH ☐ PORTUGUESE ☐ SPANISH ☐ MANDARIN ☐ CANTONESE ☐ KOREAN
OTHER: _____ NOTE: If patient is unable to read or speak English they **MUST** be accompanied by an interpreter.

REASON FOR REFERRAL

SCREENING PROCEDURE: ☐ COLONOSCOPY ☐ GASTROSCOPY (EGD) ☐ COLONSCOPY AND ECG

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 1 ☐ TYPE 2 ☐

☐ BLEEDING DISORDER: _____ | ☐ ON ANTICOAGULANTS: NAME OF TREATMENT _____

☐ PREVIOUS REACTION TO ANAESTHESIA ☐ MALIGNANT HYPERTHERMIA. DATE: _____

OTHER:

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: