ONTARIO COLONOSCOPY CLINICS

The path to prevention.

REFERRAL FORM

ALL PATIENTS MUST BE REFERRED BY A PHYSICIAN

PATIENT NAME _____ DATE OF BIRTH _____

OHIP NUMBER _____ PHONE # ( ) _____

REASON FOR REFERRAL:

O SCREENING O FOBT POSITIVE O OTHER _____

MEDICAL HISTORY: _____

_____

_____

MEDICATIONS: _____

_____

ALLERGIES: _____

_____

SPECIFIC OCC SURGEON:

O DR. NELSON KING O DR. ROBERTA MINNA

O DR. RYAN HEISLER O DR. FAIZ DAUDI O NEXT AVAILABLE

PREFERRED WEEKDAY: _____ AM/PM

DOCTOR'S NAME _____

DOCTOR'S ADDRESS _____

DOCTOR'S SIGNATURE _____ REFERRING OHIP #_____

PLEASE FAX REFERRAL TO 416.749.9446

40 Westmore Drive, Suite 209
Etobicoke, ON, M9V 4C2

P 416.749.9444 F 416.749.9446
www.ontariocolonoscopyclinics.ca