VAUGHAN ENDOSCOPY CLINIC

Vaughan Endoscopy Clinic Inc.
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PATIENT REFERRAL FORM

(please PRINT and fax to **905-856-2602**)

Please note that patients are higher risk for Out-of-Hospital procedures if they have any of the following criteria:

• has *significant* cardiovascular, respiratory, renal, neurological, or liver disease	• is an insulin dependent or brittle diabetic
• had a heart attack ≤ 1 year, or has cardiac stents	• is morbidly obese (BMI > 40)
• on Coumadin, Plavix, Ticlid, s.c. heparin, Pradex, or warfarin	• uses CPAP for sleep apnea and has a BMI >35

Per the above criteria, is this patient suitable for referral to the VEC ? Yes ❑ If in doubt please provide details and we will assess on a case-by-case basis: _____

PATIENT INFORMATION: ***(you may provide patient identification sticker here)***

Patient Name: (First) (Last)	
Birth Date:_____ Age:_____ **(day/ month/ year)**	**OHIP #:** **Version code:**
Sex: ❑ M ❑ F	**Address:**
Phone #: **Fax #:** **Email:**	

REASON(S) FOR THIS REFERRAL TO VEC: ***(check all that apply)***

- **Age ≥ 50 years** ❑
- **Colonic Symptoms (specify):** ❑
  _____
- **First Screening Colonoscopy** ❑
  Must be ≥ 50 years of age unless symptomatic or significant family history as defined below
- **Family History of Colon Cancer/Polyps** ❑
  If < 50 years old must have one 1st degree relative or ≥ two second degree relatives affected. Age to start screening is 10 years younger than affected relative.
- **Stool for Occult Blood +ve (FOBT+)** ❑
- **Follow-up Surveillance Colonoscopy** ❑
- **Other (specify):** ❑

_____

_____

_____

Include copies of all relevant lab results

- *if the patient requires both a colonoscopy and an OGD please specify here:* **DOUBLE PROCEDURE** ❑
- *if the patient only requires an OGD alone please specify here:* **GASTROSCOPY ONLY** ❑

REFERRING DOCTOR: (please provide physician **billing #** if not done so already: _____)

Physician Name/ Address Stamp:	**Phone:** **Fax:**

Today's Date: _____ **Referring Physician Signature: _____**