



VAUGHAN  
ENDOSCOPY  
CLINIC

Vaughan Endoscopy Clinic Inc.  
4610 Highway #7 suite. 200, Vaughan, Ontario L4L 4Y7  
Phone 905-856-2626 or 416-516-COLO fax: 905-856-2602  
www.vaughanendoscopy.com endoscopy@rogers.com

## PATIENT REFERRAL FORM

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

**Please note that the patient should not be referred to the VEC if they have any of the following criteria:**

*(if so please arrange an appropriate referral to one of our gastroenterologist's office)*

<ul style="list-style-type: none"> <li>• has significant cardiovascular, respiratory, renal, neurological, or liver disease</li> </ul>	<ul style="list-style-type: none"> <li>• requires prophylactic antibiotics for previous endocarditis, mechanical heart valve, or complex cardiac congenital abnormalities</li> </ul>
<ul style="list-style-type: none"> <li>• uses CPAP for sleep apnea</li> </ul>	<ul style="list-style-type: none"> <li>• had a heart attack <math>\leq</math> 1 year, or has cardiac stents</li> </ul>
<ul style="list-style-type: none"> <li>• is on continuous narcotic use</li> </ul>	<ul style="list-style-type: none"> <li>• is morbidly obese</li> </ul>
<ul style="list-style-type: none"> <li>• is an insulin dependent or brittle diabetic</li> </ul>	<ul style="list-style-type: none"> <li>• is on Coumadin, Plavix, Ticlid, or s.c. heparin</li> </ul>

Per the above criteria, is this patient suitable for referral to the VEC ?      Yes

Does the patient have significant/ serious GI complaints?       Yes    No

*If yes, please arrange an appropriate referral to one of our gastroenterologist's office.*

**PATIENT INFORMATION:**      *(can provide patient identification sticker)*

<b>Patient Name:</b>	
(First)	(Last)
<b>Birth Date:</b> _____ <b>Age:</b> _____	<b>OHIP #:</b>
(day/ month/ year)	<b>Version code:</b>
<b>Sex:</b> <input type="checkbox"/> M <input type="checkbox"/> F	<b>Address:</b>
<b>Phone #:</b>	
<b>Fax #:</b>	

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

- Age  $\geq$  50 years
- First Screening Colonoscopy
- Family history of colon cancer/polyps
- Stool for occult blood +ve
- Follow-up Surveillance Colonoscopy
- Mild Colonic symptoms
- Other (specify): \_\_\_\_\_

*NB: Upper Endoscopies are not individually provided, however if the patient requires both a screening colonoscopy and an OGD for mild symptoms, please specify under "other" above and we will schedule both procedures together.*

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

<b>Physician Name:</b>	<b>Phone:</b>
	<b>Fax:</b>

**Today's Date:** \_\_\_\_\_

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