

Division of Gastroenterology – TWH GI Clinic Referral Form

Please complete and fax to **416-603-5039**
***Please include all relevant clinic notes, procedure reports, tests results, imaging, etc.**
 All referrals will be triaged and booked based on **urgency & availability.**

Choose one of the following:

- FIT Positive test result** (prioritized assessment by the FIT clinical coordinator in 7 working days)
- 1st available appointment for one of the following GI specialists (**recommended**)
- Referral direct to:** Dr. Maria Cino Dr. Louis Liu Dr. Herbert Gaisano Dr. Colleen Parker Dr. Yvonne Tse

URGENT referral to be seen within 10 working days (**Only for TWH internal referrals**)

Urgent Referral Criteria

Indicate reason for urgent referral (must be one of the following): <ul style="list-style-type: none"> <input type="checkbox"/> Hemodynamically stable GI bleed <input type="checkbox"/> Persistent rectal bleeding <input type="checkbox"/> New onset unexplained anemia <input type="checkbox"/> Bloody diarrhea > 14 days <input type="checkbox"/> Query primary cancer of the GI tract 	Ask the patient to bring the following to their appointment: <ol style="list-style-type: none"> 1) Health Card 2) List of current medications, including vitamins/supplements 3) List of current health care providers
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Patient information (print or label)

Referring MD information (print or stamp)

Last: _____ First: _____ Sex: M F DOB: DD ____ MM ____ YYYY ____ OHIP #: _____ Address: _____ City _____ Prov _____ Postal Code _____ Phone: _____	Name: _____ Billing Number: _____ Address: _____ City _____ Prov _____ Postal Code _____ Phone: _____ Fax: _____
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Reason for Referral:

Office Use Only	Direct to Scope	Clinic Consult	<i>(Circle One)</i>
Date Triaged: _____	Book within: _____	Week(s)	____ Month(s)