UHN Canada's #1 Hospital

Driscoll Family Digestive Health Centre
Toronto Western Hospital
399 Bathurst St, Toronto, ON M5T 2S8
Endoscopy Unit: 4th Floor East Wing

FULLY COMPLETE & FAX TO: 416-603-6204

Referral date:_____
(dd-mm-yyyy)

PATIENT LAST NAME:			PATIENT FIRST NAME:
HEALTH CARD #:	VER CODE:		DATE OF BIRTH (DD-MM-YYYY):
☐ SELF PAY			☐ OUT OF PROV: _____
SEX ON HEALTH CARD: ☐ M ☐ F ☐ X	GENDER:		☐ Interpreter Required Language spoken:
ADDRESS:			PRIMARY PHONE #:
CITY:	PROV.	POSTAL CODE:	SECONDARY PHONE #:

SPECIALITY CLINIC:

☐ **Nutrition Clinic**
Use referral form:
https://www.uhn.ca/UHNReferrals/Nutrition-Clinic-Referral-Form.pdf

☐ **Inflammatory Bowel Disease Clinic**
Use Referral Form:
https://www.uhn.ca/UHNReferrals/IBD-TWH-Referral-Form.pdf

Centralized FIT Referral Program
☐ **MUST** attach copy of positive FIT result

☐ **Capsule Endoscopy**
Use referral form:
https://www.uhn.ca/UHNReferrals/Small_Bowel_Wireless_Capsule_Endoscopy_Referral_Form.pdf

Has the patient been assessed by a Gastroenterologist in the past 48 months?
☐ NO ☐ YES → Name: _____

ATTACH ALL RELEVANT INFORMATION

☐ Current Medication & Allergy List
☐ Endoscopic & Imaging Reports
☐ Past Medical & Surgical History
☐ Laboratory and Pathology reports

SYMPTOMS:

☐ Anemia
☐ Dysphagia
☐ GI bleeding
☐ Vomiting
☐ Abnormal physical exam
☐ Abnormal imaging study
☐ Significant weight loss

DURATION OF SYMPTOMS:

☐ Weeks
☐ Months
☐ Years

REFERRING PROVIDER

NAME:			OHIP BILLING #:
PHONE #:		FAX #:	
ADDRESS:	CITY:	PROV:	POSTAL CODE:

ADDITIONAL COMMENTS FOR REFERRAL:

Date Triaged:	**Book Within:** _____ **Week (s)/** _____ **Month(s)**