GHA | SURGICAL CENTRE

REFERRAL FORM

726 UPPER JAMES ST., HAMILTON, ON L9C 2Z9
PHONE: 905-575-5743 X 4 – **FAX: 905-575-7711**
http://www.ghasurgicalcentre.ca

- ☐ **URGENT**
- ☐ PAST PT OF GHA
- ☐ FEMALE SURGEON ONLY

REFERRING PHYSICIAN/NP INFORMATION:
(LABEL/STAMP HERE)

PHYSICIAN/NP: ____
OFFICE PHONE#: ____
OFFICE FAX#: ____

BILLING#: ____

PATIENT INFORMATION: *(PATIENT LABEL HERE)*

FULL NAME: ____
DATE OF BIRTH (Y/M/D): ________________________________
PHONE NUMBER: ____________________________________
HEALTHCARD/UHIP/IFH#: ______________________________
ADDRESS: ____
____
HT: ________(IN/CM) – WT: ________(LB/KG) – BMI: _____

*PLEASE COMPLETE SECTIONS 1-4- **INCOMPLETE REFERRALS *WILL NOT* BE ACCEPTED***

1. REASON FOR REFERRAL:

- ☐ COLONOSCOPY
- ☐ FLEXIBLE SIGMOIDOSCOPY
- ☐ HEMORRHOID BANDING
- ☐ GASTROSCOPY
- ☐ MINOR COSMETIC PROCEDURE *(SKIP TO QUESTION '3b')*

a) ASYMPTOMATIC:

- ☐ COLON SCREEN *(50 YEARS OF AGE+/FIRST COLONOSCOPY)*
- ☐ FOLLOW UP SURVEILLANCE/H/O COLONIC POLYPS
  (ATTACH MOST RECENT COLONOSCOPY REPORT + RESULTS)
- ☐ FAMILY H/O COLORECTAL CANCER/COLONIC POLYPS
  RELATION(S) + AGE WHEN DIAGNOSED:
  ____
  ____
- ☐ FOBT+
- ☐ FAMILY H/O GASTRIC OR STOMACH CANCER/POLYPS/DUE FOR FOLLOW UP GASTROSCOPY
- ☐ OTHER:

b) SYMPTOMATIC:

- ☐ ABDOMINAL PAIN
- ☐ BRBPR/RECTAL BLEEDING
- ☐ DIARRHEA
- ☐ CONSTIPATION
- ☐ RECTAL DISCHARGE/PUS
- ☐ NAUSEA
- ☐ VOMITING
- ☐ HEMATEMESIS
- ☐ ANEMIA/LOW HB
  (ATTACH RELATED BLOOD WORK, MUST BE DONE WITHIN 3-6 MTHS OF THIS REFERRAL)
- ☐ HEARTBURN
- ☐ BLOATING
- ☐ LOSS OF APPETITE
- ☐ WEIGHT LOSS
- ☐ RECTAL PAIN
- ☐ DYSPHAGIA
- ☐ DYSPEPSIA
- ☐ GERD
- ☐ OTHER:

2. HAS PT BEEN DIAGNOSED WITH ANY OF THE FOLLOWING STOMACH/BOWEL CONDITIONS? *(MARK ALL THAT APPLY)*

- ☐ CELIAC DISEASE
- ☐ DIVERTICULITIS
- ☐ LACTOSE INTOLERANCE
- ☐ FOOD INTOLERANCE
- ☐ BARRETT'S ESOPHAGUS
- ☐ IBS
- ☐ COLITIS
- ☐ CROHN'S DISEASE
- ☐ COLON CANCER
- ☐ STOMACH/GASTRIC CANCER

****ALL RELEVANT INVESTIGATIONS MUST BE ATTACHED TO REFERRAL (U/S, XR, CT, MRI, BLOOD WORK, SPECIALIST NOTES, ETC.)**

3. MEDICAL HISTORY:

a) PLEASE INDICATE IF THE PT HAS ANY OF THE FOLLOWING MEDICAL CONDITIONS OR,

- ☐ ***NO SIGNIFICANT MEDICAL CONCERNS***
- ☐ ***CPP ATTACHED***

- ☐ DIABETES: TYPE 1 OR TYPE 2
- ☐ HEART CONDITIONS (H/O MI, CAD)
- ☐ RESPIRATORY ISSUES (ASTHMA, COPD)
- ☐ H/O OR FMHX OF MALIGNANT HYPERTHERMIA
- ☐ SLEEP APNEA
- ☐ RENAL DISEASE
- ☐ LIVER DISEASE/EXCESSIVE ETOH USE (14+ DRINKS/WK)
- ☐ LIMITED EXERCISE TOLERANCE
- ☐ H/O ADVERSE REACTION TO SEDATION/ANESTHETIC
- ☐ MORBID OBESITY

b) MEDICATION- ***PLEASE LIST CURRENT MEDICATIONS, OR:***

- ☐ ***NO MEDICATION***
- ☐ ***MEDICATION LIST ATTACHED***
- ☐ ***ANTICOAGULANTS AND/OR ASA***

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4. MINOR COSMETIC PROCEDURES:

(PLEASE NOTE THAT THE CONSULTATION APPOINTMENT IS COVERED BY OHIP)

- ☐ SEBACEOUS CYSTS
- ☐ CHRONIC SKIN GRANULOMA
- ☐ DERMATOFIBROMA
- ☐ MOLES
- ☐ PILAR CYSTS OF SCALP
- ☐ SKIN TAGS OR ANAL SKIN TAGS
- ☐ EPIDERMAL CYSTS
- ☐ LIPOMA
- ☐ PERIANAL SKIN LESIONS
- ☐ HEMANGIOMA
- ☐ RAISED SKIN LESIONS