

726 UPPER JAMES ST., HAMILTON, ON L9C 2Z9
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<http://www.ghasurgicalcentre.ca>

<input type="checkbox"/> URGENT
<input type="checkbox"/> PAST PT OF GHA
<input type="checkbox"/> FEMALE SURGEON ONLY

REFERRING PHYSICIAN/NP INFORMATION: (LABEL/STAMP HERE)	PATIENT INFORMATION: (PATIENT LABEL HERE)
PHYSICIAN/NP: _____	FULL NAME: _____
OFFICE PHONE#: _____	DATE OF BIRTH (Y/M/D): _____
OFFICE FAX#: _____	PHONE NUMBER: _____
	HEALTHCARD/UHIP/IFH#: _____
	ADDRESS: _____
BILLING#: _____	HT: _____ (IN/CM) – WT: _____ (LB/KG) – BMI: _____

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

1. REASON FOR REFERRAL:

<input type="checkbox"/> COLONOSCOPY	<input type="checkbox"/> GASTROSCOPY
<input type="checkbox"/> FLEXIBLE SIGMOIDOSCOPY	<input type="checkbox"/> MINOR COSMETIC PROCEDURE
<input type="checkbox"/> HEMORRHOID BANDING	<i>(SKIP TO QUESTION '3b')</i>

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:

<input type="checkbox"/> ABDOMINAL PAIN	<input type="checkbox"/> HEARTBURN
<input type="checkbox"/> BRBPR/RECTAL BLEEDING	<input type="checkbox"/> BLOATING
<input type="checkbox"/> DIARRHEA	<input type="checkbox"/> LOSS OF APPETITE
<input type="checkbox"/> CONSTIPATION	<input type="checkbox"/> WEIGHT LOSS
<input type="checkbox"/> RECTAL DISCHARGE/PUS	<input type="checkbox"/> RECTAL PAIN
<input type="checkbox"/> NAUSEA	<input type="checkbox"/> DYSPHAGIA
<input type="checkbox"/> VOMITING	<input type="checkbox"/> DYSPEPSIA
<input type="checkbox"/> HEMATEMESIS	<input type="checkbox"/> GERD
<input type="checkbox"/> ANEMIA/LOW HB	<input type="checkbox"/> OTHER: _____

(ATTACH RELATED BLOOD WORK, MUST BE DONE WITHIN 3-6 MTHS OF THIS REFERRAL)

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

<input type="checkbox"/> CELIAC DISEASE	<input type="checkbox"/> IBS
<input type="checkbox"/> DIVERTICULITIS	<input type="checkbox"/> COLITIS
<input type="checkbox"/> LACTOSE INTOLERANCE	<input type="checkbox"/> CROHN'S DISEASE
<input type="checkbox"/> FOOD INTOLERANCE	<input type="checkbox"/> COLON CANCER
<input type="checkbox"/> BARRETT'S ESOPHAGUS	<input type="checkbox"/> STOMACH/GASTRIC CANCER

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

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

EPIDERMAL CYSTS

LIPOMA

HEMANGIOMA

RAISED SKIN LESIONS

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