Middlesex Hospital Alliance

Strathroy ☐ Four Counties ☐

☐ Dr. Jain	Fax: 519-245-7806 (SMGH Only) Phone: 519 246-6321
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☐ Dr. Mohammed	Fax: 519-704-1160 (SMGH & FCHS) Phone: 519-519-383-1585

ENDOSCOPY UNIT REFERRAL

Patient Name:	Phone Number:
Date of Birth:	OHIP Number:
Exam requested: ☐ Colonoscopy ☐ Upper Endoscopy	Address:

Indications: Colonoscopy	**Primary** ✓ 1st one that applies	**Secondary** ✓all that apply
Abnormal FIT (Fecal Immunochemical Test)	☐	NA
Abnormal FOBT (Fecal Occult Blood Test)	☐	NA
Symptoms or abnormal test (not FIT, FOBT) ☐ abnormal test or imaging ☐ rectal bleeding ☐ anemia ☐ discomfort ☐ change in bowel habits	☐	☐
First Degree Relative (parent, sibling, child) with Colorectal Cancer	☐	☐
Surveillance of previous ☐ colorectal neoplasm ☐ IBD ☐ Polyps	☐	☐
Other Screening ☐ Over 50 ☐ Extended family history colorectal cancer	☐	☐

Indications: Upper Endoscopy (✓all that apply)

☐ Abdominal Pain ☐ Dyspepsia/Vomiting ☐ Dysphagia ☐ Heartburn / GERD

☐ Anemia- last hgb level _____ Date: _____ Other: _____

Medical History (✓all that apply)

☐ Diabetes ☐ Oral Meds ☐ Insulin

☐ Blood Thinner ☐ Coumadin ☐ ASA ☐ Plavix

☐ Other Anticoagulant _____

☐ Mechanical Heart Valve

☐ Prior Colonoscopy Date _____

☐ Prior Upper Endoscopy Date_____

☐ Heart Disease

☐ Hypertension

☐ Renal Disease

☐ Respiratory Disease

☐ MRSA ☐ VRE

Referring Physician: please print	Date:
Physician Signature:	Phone: Fax:

Referring physicians are asked to provide patient with basic understanding of the procedure, bowel preparation, information regarding cessation of blood thinners prior to the procedure and interpreter if required.