

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

<input type="checkbox"/> <b>URGENT</b> <input type="checkbox"/> PAST PT OF GHA <input type="checkbox"/> FEMALE SURGEON ONLY
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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: _____		
BILLING#: _____	HEALTHCARD/ UHIP/ IFH#: _____		
	ADDRESS: _____		
	HT: (IN/ CM)	WT: (LB/KG)	BMI:

\*\*\*PLEASE COMPLETE SECTIONS 1-4

\*\*\*PLEASE ATTACH CPP AND MEDICATION LIST

\*\*\*REFER TO HOSPITAL-BASED CARE FOR Hgb <80 g/L

\*\*\*FOR LUMPS AND BUMPS REFERRAL  
PLEASE REFER TO OUR LUMPS AND BUMPS FORM

\*\*\*INCOMPLETE FORMS WILL NOT BE ACCEPTED

1. REASON FOR REFERRAL: (AGE 18 - 85 YEARS)	
<input type="checkbox"/> COLONOSCOPY <input type="checkbox"/> FLEXIBLE SIGMOIDOSCOPY <input type="checkbox"/> HEMORRHOID BANDING <i>(INTERNAL ONLY)</i>	<input type="checkbox"/> GASTROSCOPY <input type="checkbox"/> MINOR COSMETIC PROCEDURE
<b>a) ASYMPTOMATIC:</b> <input type="checkbox"/> COLON SCREEN (50 YEARS OF AGE+/FIRST COLONOSCOPY) <input type="checkbox"/> FOLLOW UP SURVEILLANCE/H/O COLONIC POLYPS <i>(ATTACH MOST RECENT COLONOSCOPY REPORT + RESULTS)</i> <input type="checkbox"/> FAMILY H/O COLORECTAL CANCER/COLONIC POLYPS <i>RELATION(S) + AGE WHEN DIAGNOSED:</i>	
<input type="checkbox"/> FAMILY H/O GASTRIC OR STOMACH CANCER/POLYPS/ DUE FOR FOLLOW UP GASTROSCOPY <input type="checkbox"/> OTHER	
<b>B) SYMPTOMATIC:</b> <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 APETITE <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"/> VOMITTING <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 MONTHS OF THIS REFERRAL)	

2. HAS PT BEEN DIAGNOSED WITH ANY OF THE FOLLOWING STOMACH/ BOWEL CONITIONS? (MARK ALL THAT APPLY)	
<input type="checkbox"/> CELIAC DISEASE <input type="checkbox"/> DIVERTICULITIS <input type="checkbox"/> LACTOSE INTOLERANCE <input type="checkbox"/> FOOD INTOLERANCE <input type="checkbox"/> BARRETT'S ESOPHAGUS	<input type="checkbox"/> IBS <input type="checkbox"/> COLITIS <input type="checkbox"/> CROHN'S DISEASE <input type="checkbox"/> COLON CANCER <input type="checkbox"/> STOMACH/GASTRIC CANCER

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

3. MEDICAL HISTORY:
<b>a) PLEASE INDICATE IF THE PT HAS ANY OF THE FOLLOWING MEDICAL CONDITIONS OR.</b> <input type="checkbox"/> NO SIGNIFICANT MEDICAL CONCERNS <input type="checkbox"/> CPP ATTACHED  <input type="checkbox"/> DIABETES: TYPE 1 OR TYPE 2 <input type="checkbox"/> HEART CONDITIONS (MI/CAD/AFIB/CABG) <input type="checkbox"/> RESPIRATORY ISSUES (ASTHMA, COPD) <input type="checkbox"/> H/O OR FMHX OF MALIGNANT HYPERTHERMIA <input type="checkbox"/> SLEEP APNEA <input type="checkbox"/> HYPERTENSION <input type="checkbox"/> RENAL DISEASE <input type="checkbox"/> LIVER DISEASE/ EXCESSIVE ETOH USE (14+ DRINKS/WK) <input type="checkbox"/> LIMITED EXERCISE TOLERANCE <input type="checkbox"/> H/O ADVERSE REACTION TO SEDATION /ANESTHETIC <input type="checkbox"/> MORBID OBESITY
<b>b) MEDICATION- PLEASE LIST CURRENT MEDICATIONS, OR:</b> <input type="checkbox"/> NO MEDICATION <input type="checkbox"/> MEDICATION LIST ATTACHED <input type="checkbox"/> ANTICOAGULANTS AND/OR ASA

4. HYDROGEN/ METHANE BREATH TEST:
<input type="checkbox"/> LACTOSE INTOLERANCE (MALABSORPTION) <input type="checkbox"/> FRUCTOSE INTOLERANCE (MALABSORPTION) <input type="checkbox"/> SMALL INTESTINAL BACTERIAL OVERGROWTH (GLUCOSE/LACTULOSE)  <input type="checkbox"/> IF POSITIVE, PLEASE REFER TO GASTROENTEROLOGIST  *** THIS IS NOT COVERED BY OHIP. A \$150.00 FEE IS PAYABLE PRIOR TO THE APPOINTMENT. NO HST WILL BE ADDED.

\*\*\*UPDATED EXCLUSION CRITERIA AVAILABLE ON OUR WEBSITE

\*\*\*WE ACCEPT REFERRALS FOR FIT POSITIVE PATIENTS