VAUGHAN ENDOSCOPY CLINIC

Vaughan Endoscopy Clinic Inc.
4610 Highway #7 suite. 200, Vaughan, Ontario L4L 4Y7
Phone 905-856-2626 or 416-516-COLO Fax: 905-856-2602
www.vaughanendoscopy.com endoscopy@rogers.com

PATIENT REFERRAL FORM

(please print and fax to **905-856-2602**)

Please note that patients are higher risk for Out-of-Hospital procedures if they have any of the following criteria:

• Has *significant* cardiovascular, respiratory, renal, neurological, or liver disease	• Is an insulin dependent or brittle diabetic
• Had a heart attack < 1 year, or has cardiac stents	• Is morbidly obese (BMI > 40) • Uses CPAP for sleep apnea and has a BMI >35
• On Coumadin, Plavix, Ticlid, s.c. heparin, Pradex, warfarin, or other blood thinners other than ASA (aspirin).	• Age < 18 or > 80 years

Per the above criteria, is this patient suitable for referral to the VEC ? Yes ❑

If in doubt please provide details and we will assess on a case-by-case basis:

_____

PATIENT INFORMATION: ***(you may provide patient identification sticker here)***

Patient Name: _____ _____
(First) (Last)

Birth Date: _____ **Age:** _____
(Day/ Month/ Year)

Sex: ❑ M ❑ F

OHIP #: _____
Version code: _____

Phone: _____
Fax : _____
Email: _____

Address: _____
_____
_____

REASON(S) FOR THIS REFERRAL TO VEC: ***(check all that apply)***

- **Age > 50 years:** ❑
- **Colonic Symptoms (specify):** ❑

  _____
- **First Screening Colonoscopy** ❑

  Must be > 50 years of age unless symptomatic or significant family history as defined below
- **Family History of Colon Cancer/Polyps** ❑

  If < 50 years old must have one 1st degree relative or > two second degree relatives affected. Age to start screening is 10 years younger than affected relative.
- **Stool for Occult Blood +ve (FOBT+)** ❑
- **Follow-up Surveillance Colonoscopy** ❑
- **Other (specify):** ❑

_____
_____
_____
_____
_____
_____

Include copies of all relevant lab results

If the patient requires both a colonoscopy and an OGD please specify here: **DOUBLE PROCEDURE** ❑
If the patient only requires an OGD alone please specify here: **GASTROSCOPY ONLY** ❑

REFERRING DOCTOR: (please provide physician **billing #** if not done so already: _____)

Physician Name/ Address Stamp:	**Phone:** _____ **Fax:** _____

Today's Date: _____ **Referring Physician Signature:** _____