Southern Ontario Endoscopy Centre

6124 Tecumseh Road East, Windsor, ON N8T 1E6
Phone: (519) 915-9494 Fax: (519) 915-9493

Referring Physician: ______________________________

Billing Number: ______________________ Fax Number: ______________________

Address: ______________________________
(Street Number & Suite, City and Postal Code)

PATIENT INFORMATION

Last Name: ______________________ First Name: ______________________

OHIP: ______________________ VC: __________ Sex: M / F

DOB *(MM/DD/YY)*: _______/_________/________ Height: _______ Weight: _______ lbs/kg Age: _______

Address: ______________________________ Phone #: ______________________
(Street Number & Suite, City and Postal Code)

*Please Note: If your patient does not speak/write English, an interpreter **must** be present at the time of the procedure. Also, if your patient is unable to sign consent due to a mental disability, a power of attorney **must** be present throughout the procedure.

SERVICE REQUESTED

□ GASTROSCOPY □ DILATATION □ DUODENAL BIOPSY □ COLONOSCOPY

Past colonoscopy □ Yes □ No **If yes, please attach records □ FIT +

Presenting Complaint:
____
____

Physician Signature: ______________________ Referral Date: ______________________

MEDICAL INFORMATION

Does your patient use any of the following medications?
□ Coumadin (Warfarin) □ Aspirin □ Plavix □ Pradaxa □ Xarelto □ Iron Pills □ NSAIDs □ Vitamins
Other Medications: ______________________________
Please attach a list of medications.

Allergies: ______________________________

Does your patient have a history of?
□ Angina/MI □ Diabetes □ Stroke/TIA □ Sleep Apnea □ Asthma/COPD □ Stents/Bypass
Other: ______________________________
If there is a history of cardiac disease please attach most recent ECG and Cardiology Consult Report

Appointment Date: ______________________ **Time:** __________ **Notified: Y/N**

□ Prep kit