ONTARIO COLONOSCOPY CLINICS

Referral Form: ALL PATIENTS MUST BE REFERRED BY A PHYSICIAN BY FAX TO (416)749-9446

Patient Name_____ **Date of Birth**____/____/____

OHIP Number_____ **Phone#**_____

Reason for Referral: (Circle One)

Colon Screening **Abnormal FIT** **Family Hx of Colon CA/Colon Polyps**

Other (Please specify) _____

Medical History:

_____

_____

Sleep Apnea **CPAP (Y/N)** **Mechanical Heart Valve**

Weight_____Lbs/Kg **Height**_____Ft/cm **BMI**_____

Insulin_____

Blood Thinner (name of medication)_____

Allergies_____

Medications_____

_____

Specific OCC Surgeon: (Please circle one)

Dr. Roberta Minna **Dr. Nelson King** **Dr. Ryan Heisler** **Dr. Faiz Daudi** **Next Available**

Doctors Name and Billing #_____

Signature_____