



REFERRAL REQUEST FORM

GreeneStone Medical Clinic
3571 Muskoka Road 169,
P.O. Box 660, Bala,
Ontario, P0C 1A0

Phone: 1-705-762-5501
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Email: info@greeneStone.ca
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Patient Name: _____	OHIP No: _____	Physician Billing No: _____
D.O.B. (dd/mm/yyyy): _____	Referring Physician: _____	Physician email: _____
Patient Phone No: _____	Physician Fax No: _____	Patient email: _____

Reason for referral (please check all that apply)

Gastroscopy	Colonoscopy
<input type="checkbox"/> Abdominal Pain	<input type="checkbox"/> Abdominal Pain
<input type="checkbox"/> Anemia	<input type="checkbox"/> Anemia
<input type="checkbox"/> Bloating	<input type="checkbox"/> Bloating/Gas/Flatulence
<input type="checkbox"/> Dysphagia	<input type="checkbox"/> Blood In Stool
<input type="checkbox"/> Dyspepsia	<input type="checkbox"/> Colon Screening
<input type="checkbox"/> other (Specify)	<input type="checkbox"/> Other (specify)
<input type="checkbox"/> Nausea	<input type="checkbox"/> Constipation
<input type="checkbox"/> Odonophagia	<input type="checkbox"/> Diarrhea
<input type="checkbox"/> Reflux Symptons (GERD)	<input type="checkbox"/> History of IBD
<input type="checkbox"/> Weight Loss	<input type="checkbox"/> History of Polyps
	<input type="checkbox"/> Weight Loss

Medical History:

Medications:

Allergies: