



REFERRAL REQUEST FORM

GreeneStone Muskoka
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|------------------------------|---------------------------------|
| Patient Name: _____ | Physician Phone Number: _____ |
| Birthday (dd/mm/yyyy): _____ | Physician E-mail: _____ |
| Patient Phone Number: _____ | Physician Billing Number: _____ |
| Patient E-mail: _____ | Referring Physician: _____ |
| OHIP Number: _____ | Physician Fax: _____ |

Reason for referral (please check all that apply)

Physician Signature: _____

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| Gastroscopy | |
| <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Odonophagia |
| <input type="checkbox"/> Bloating | <input type="checkbox"/> Reflux Symptoms (GERD) |
| <input type="checkbox"/> Dysphagia | <input type="checkbox"/> Weight Loss |
| <input type="checkbox"/> Dyspepsia | <input type="checkbox"/> Other (please specify) |

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| Colonoscopy | |
| <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Bloating/Gas/Flatulence | <input type="checkbox"/> History of IBD |
| <input type="checkbox"/> Blood In Stool | <input type="checkbox"/> History of Polyps |
| <input type="checkbox"/> Colon Screening | <input type="checkbox"/> Weight Loss |

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| Medical History: |
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| Allergies: |
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| Medications: |
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