University Health Network – Toronto Western Hospital
399 Bathurst Street, 4th floor, East Wing • Toronto, ON M5G 2C4

Date:_____

Toronto Western Hospital Gastroenterology Clinic Referral Form

Please complete and fax to **416-603-5039**
***Please include all relevant clinic notes, procedure reports, tests results, imaging, etc.**
All referrals will be triaged and booked based on **urgency & availability.**

Choose one of the following:

☐ **FIT Positive test result** (prioritized assessment by the FIT clinical coordinator in 7 working days)

☐ 1st available appointment for one of the following GI specialists (***recommended***)

Referral direct to: ☐ Dr. Maria Cino ☐ Dr. Louis Liu ☐ Dr. Herbert Gaisano ☐ Dr. Colleen Parker ☐ Dr. Yvonne Tse

☐ ***URGENT*** referral to be seen within 10 working days (***Only for TWH internal referrals***)

Urgent Referral Criteria

Indicate reason for urgent referral (**must** be one of the following):	Ask the patient to bring the following to their appointment:
☐ Hemodynamically stable GI bleed ☐ Persistent rectal bleeding ☐ New onset unexplained anemia ☐ Bloody diarrhea > 14 days ☐ Query primary cancer of the GI tract	1) Health Card 2) List of current medications, including vitamins/supplements 3) List of current health care providers

Patient information (print or label)

Last:_____ **First:**_____
Sex: M F DOB: DD_____**MM** ____**YYYY**_____
OHIP #: _____
Address:_____
City_____ **Prov**_____
Postal Code _____
Phone:_____

Referring MD information (print or stamp)

Name:_____
Billing Number:_____

Address:_____
City_____ **Prov**_____
Postal Code _____
Phone:_____ **Fax:** _____

Reason for Referral:

Office Use Only	**Direct to Scope** **Clinic Consult** *(Circle One)*
Date Triaged:	Book within: ____ Week(s) ____ Month(s)