Credit Valley Endoscopy Group & Associates
PHYSICIAN REFERRAL FORM

The *NEW*

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Dr. Nav Anand	Dr. Adriano Correia	Dr. Supriya Joshi	Dr. Krishna Menon	Dr. Imran Rasul	Dr. Jennifer Shin

Patient Information

Gender M F

Patient email: ______________________________

Patient contact #:____________________________

Reason for referral (please check all that apply):

□ screening age >50
□ + FOBT
□ Fe deficiency anemia
□ family hx of cancer
□ previous polyps

□ change in bowel habit
□ rectal bleeding
□ dysphagia
□ weight loss

Test requested:

□ Colonoscopy
□ Gastroscopy
□ Colon + Gastro

Medical History
□ Diabetic (insulin or OHG)
□ Age > 75
□ CAD (angina/MI within 1 yr)
□ Asthma/COPD
□ Morbidly Obese BMI >35
□ Sleep apnea (CPAP)

Blood Thinners
□ ASA
□ Coumadin
□ Plavix
□ Other _________________

Allergies (please list)

Other notes

Referring MD: ____________________________________ Date: _____________________
Billing # _______________________

Our receptionist will contact your patient with appointment date and time and information regarding their consultation and procedure. Thank you for your referral.