3545 Odyssey Drive, Unit 18
Mississauga, ON L5M 2S4
www.westgtaendoscopy.com

Phone: (905) 823-0223
Fax: (905) 823-9780
Fax: 1-844-WESTGTA

Dr. Navin Anand | Dr. Adriano Correia | Dr. Supriya Joshi | Dr. Krishna Menon | Dr. Imran Rasul | Dr. Callum Dargavel

Physician Referral Form

Patient Information *(Place label here / Fill)*

Name:________________________________
HCN:________________________VC:______
Birthdate: _____________________________
Address:______________________________
____

Gender : Male / Female
Email : ______________________________

Contact Phone
Home : _______________________
Mobile : _______________________

Reason for referral (please check all that apply):

□ screening age ≥ 50
□ positive FOBT
□ iron deficiency anemia
□ family history of CRC:
*specify **relationship** & **age***: ______________________________
□ previous polyps
□ change in bowel habit
□ rectal bleeding
□ 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 *(Ht ______ Wt ______)*
□ Sleep apnea (CPAP)

Blood Thinners
□ ASA
□ Coumadin
□ Plavix
□ Other ____________

Allergies (please list):
____
____
____
____
____

Other notes:

Referring MD: ______________________________________
Address: ____
Tel: _______________________ Fax: ____________________

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!**