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

Date:_____

Division of Gastroenterology – TWH GI 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:

☐ 1st available (*recommended*)

☐ ***FIT Positive test result***

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

OR

☐ *URGENT* referral to be seen within 7 working days (***For TWH internal use only***)

For Urgent Referral ONLY (TWH internal use only)

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)	**Referring MD information (print or stamp)**
Last:_____ First:_____ **Sex: M F DOB: DD_____MM ____YYYY_____** **Address:_____** **City_____ Prov_____** **Postal Code _____** **Phone:_____**	**Name:_____** **Billing Number:_____** **Address:_____** **City_____ Prov_____** **Postal Code _____** **Phone:_____ Fax: _____**

Reason for Referral

Date Triaged:	Book within: ____ Week(s) ____ Month(s)