DR E A LALOR
GASTROENTEROLOGY AND ENDOSCOPY
REFERRAL FORM
(also available by E-Consult)

Telephone: (705) 719-3996 **Fax: (705) 719-3998**

Date of referral:

Patient's Name (Surname/First Name) **Email**	**Referring Practitioner Name:** **NP DR** **Primary Care Physician Name:**
Patient's Address **Gender**	**Referring Practitioners address:**
Health Card # with version code **DOB**	**Referring OHIP #**
Home Phone **Cell Phone** **Work Phone**	**Referring office Phone #**

Reason for Referral: (Please attach additional information to a maximum of 10 pages - no labs please - we have OLIS access)

Office: Yes No **Direct to: Colonoscopy Gastroscopy ERCP**

Medication List (or attach):

Please indicate if patient is currently taking one of these blood thinners other than ASA: More than one?

BMI Height Weight Sleep Apnea

Malignant Hyperthermia

Past Medical History: Check all that apply.

Cardiac
Respiratory
Diabetic Insulin
Non- Insulin Requiring
Neurologic
Creatinine > 150

Referring Practitioner Signature