PROVINCIAL ENDOSCOPY CENTRE
Precision. Care. Discovery.

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WWW.Provincialendoscopycenter.ca

Patient & Physician Information

Date * 01/26/2026

Patient Name * Last, First

Referring Physician *

Health Card No. *

Patient Address *

Physician Address *

Gender * ○ Male ○ Female

DOB * mm/dd/yyyy

Personal Phone *

Guardian's Phone

Physician Phone *

Physician Fax

Prior Gastroscopy ○ Yes ○ No

Prior Colonoscopy ○ Yes ○ No

Reason for Referral

☐ URGENT ☐ FOLLOW UP

Procedure Requested (✓ all)
☐ GASTROSCOPY ☐ COLONOSCOPY ☐ SIGMOIDOSCOPY ☐ ANORECTAL

GASTROSCOPY
- ☐ ANEMIA
- ☐ NAUSEA
- ☐ DYSPHAGIA
- ☐ WT LOSS
- ☐ BLOATING/GAS
- ☐ DYSPEPSIA
- ☐ REFLUX

COLONOSCOPY
- ☐ ANEMIA
- ☐ POLYPS HX
- ☐ CONSTIPATION
- ☐ DIARRHEA
- ☐ RECTAL BLEED
- ☐ FAM H/O
- ☐ COLON SCRN

SIGMOIDOSCOPY
- ☐ CONSTIPATION
- ☐ DIARRHEA
- ☐ RECTAL BLEED
- ☐ CT FINDINGS
- ☐ WT LOSS

ANORECTAL
- ☐ HEMORRHOIDS
- ☐ FISSURE
- ☐ FISTULA
- ☐ FLATULENCE
- ☐ OTHERS

Exclusion Criteria

Check conditions:

CV:
- ☐ Recent MI
- ☐ CHF
- ☐ Severe HD

PULM:
- ☐ Severe COPD
- ☐ Sleep Apnea
- ☐ Morbid Obesity

LIVER:
- ☐ GI Bleed
- ☐ Liver Disease
- ☐ Jaundice

OTHER:
- ☐ Pregnant
- ☐ Non-Ambulatory

RENAL:
- ☐ Dialysis

Medications

Anticoagulants (✓ all)
☐ ASPIRIN ☐ PLAVIX ☐ WARFARIN ☐ INSULIN ☐ OTHER:

ALL MEDICATIONS:

Medical History & Comments

☐ Sedation reaction ☐ Prophylactic ABX ☐ Diabetes ☐ Heart valve

Allergies

Creatinine

☐ Interpreter needed

Comments

FAX TO: 519-946-3518
Notify 3 business days prior, otherwise cancellation fee applies.