



Office Use Only	
Appointment Date:	_____
Appointment Time:	_____
Appointment with:	_____

## Referral Request Form

Patient Name:  
 D.O.B. ( dd / mm / yyyy ):  
 Patient Phone No:

OHIP No:  
 Referring Physician:  
 Physician Fax No:

Physician Billing No:

***BOOK DIRECTLY FOR PROCEDURE***

**YES**

**OR**

**NO (consultation first)**

**REASON for Referral (please check all that apply)**

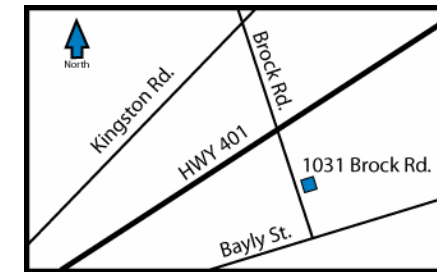
<p><b>Gastroscopy</b></p> <p><input type="checkbox"/> abdominal pain</p> <p><input type="checkbox"/> anemia</p> <p><input type="checkbox"/> bloating</p> <p><input type="checkbox"/> dysphagia</p> <p><input type="checkbox"/> dyspepsia</p> <p><input type="checkbox"/> nausea</p> <p><input type="checkbox"/> odonophagia</p> <p><input type="checkbox"/> reflux symptoms (GERD)</p> <p><input type="checkbox"/> weight loss</p> <p><input type="checkbox"/> other (specify)</p> <p>_____</p>
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<p><b>Colonoscopy</b></p> <p><input type="checkbox"/> abdominal pain</p> <p><input type="checkbox"/> anemia</p> <p><input type="checkbox"/> bloating/gas/flatulence</p> <p><input type="checkbox"/> blood in stool</p> <p><input type="checkbox"/> colon screening</p> <p><input type="checkbox"/> constipation</p> <p><input type="checkbox"/> diarrhea</p> <p><input type="checkbox"/> history of IBD</p> <p><input type="checkbox"/> history of polyps</p> <p><input type="checkbox"/> weight loss</p> <p><input type="checkbox"/> other (specify)</p> <p>_____</p>
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<p><b>Capsule Endoscopy</b></p> <p><input type="checkbox"/> specify</p> <p>_____</p> <p><input type="checkbox"/> <b>Lactose Intolerance</b></p>
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<p>Medical History:</p> <p>Medications:</p> <p>Allergies:</p>
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**72 hour cancellation notice required or the patient will be charged for the appointment**



### Preparation Instructions

#### **Instructions for Gastroscopy & Capsule Endoscopy**

Eat and Drink NOTHING after Midnight if your test is booked in the morning.

Eat and Drink NOTHING 6 HOURS before if your appt is booked for the afternoon.

#### **Instructions for the Colonoscopy**

##### **The Day before Your Appt:**

1. Once you wake up and until you go to sleep you must remain on a diet of clear fluids (NO MILK).

You can have Jello (but NOT RED), BLACK COFFEE OR TEA with sugar, CLEAR SOUP & JUICE (NO PULP), ICE POPSICLES; ALL DAY

BEFORE TAKING **KLEAN PREP** YOU MAY TAKE GRAVOL IF YOU HAVE A SENSITIVE STOMACH

2. At 6:00pm start to drink the **KLEAN PREP** solution. Dissolve the contents of one packet in 1000mL (1L) of water. Drink 250mL (one regular drinking glass) of the solution every 10 mins. Continue drinking 250mL of mixed solution every 10mins or as quickly as you can until two packets have been consumed. If you feel nauseous, slow down.

**MAKE SURE YOU FINISH BOTH PACKETS. (2 PACKETS EACH MIXED WITH ONE LITRE OF WATER)**

3. About one hour after you begin to drink **KLEAN PREP** you will start to experience a diarrhea type of bowel movement (depending on the person).

4. Remember you may drink clear fluids only to bedtime.

##### **The Morning of the Colonoscopy:**

1. Nothing to eat.

2. You may have a clear fluid breakfast only if you are scheduled for an afternoon appointment.

3. **At 6:30am or earlier**, mix the two remaining packets of KLEAN PREP. Dissolve the contents of one packet in 1000mL (1L) of water. Drink 250mL of the solution every 10mins or as quickly as you can. (FINISH the last two packets)

**Please note the following:** KLEAN PREP can be purchased at any local pharmacy without prescription. If you have drug benefits please ask for a prescription, as it is covered by most drug plans. FOR COLONOSCOPY & GASTROSCOPY; ARRANGE FOR SOMEONE TO DRIVE YOU HOME AS YOU WILL RECEIVE IV SEDATION PRIOR TO THE PROCEDURE.

Consult your physician about the use of medication during this preparation period. Heart, blood pressure, asthma and epilepsy medication may be taken in the morning as usual.