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REFERRAL REQUEST

Please complete all relevant fields and attach supporting reports.

PATIENT INFORMATION

Legal name:		Date of birth (YYYY-MM-DD):	
Health card number:		Version code:	
Address:		City / postal code:	
Primary phone:		Alternate phone:	
Preferred language:		Pronouns (optional):	

REFERRING CLINICIAN

Clinician name:		Billing / licence number:	
Clinic / organization:		Secure email:	
Phone:		Fax:	
Signature:		Date:	

REASON FOR REFERRAL

Priority: ☐ Routine ☐ Urgent - clinical rationale required below

Primary clinical question:

Relevant symptoms, duration, and functional impact:

CLINICAL INFORMATION

Relevant medical and surgical history:

Current medications and allergies:

Investigations attached: ☐ Laboratory ☐ Imaging ☐ Consultation notes ☐ Other

Additional information:

SERVICE-SPECIFIC NOTES

Common referral areas: GERD, Inflammatory bowel disease, Irritable bowel syndrome, Abnormal liver enzymes, Iron-deficiency anemia.
Submission guidance: A referral is required. Include symptom duration, alarm features, medication list, CBC, ferritin, liver enzymes, CRP, relevant stool studies, imaging, and prior endoscopy reports when available.