THE GUT CENTRE
Gastroenterology Unity Toronto

181 Sterling Road, Suite 204 Toronto, ON, M6R 2B2
T: (416) 766-3402 **F:** (647) 947-9907
booking@gutcentre.ca

PATIENT REFERRAL FORM

Fax referral to: (647) 947- 9907

REFERRAL URGENCY

☐ < 1 week ☐ < 4 weeks ☐ < 3 month ☐ Elective

PATIENT INFORMATION

LAST NAME | FIRST NAME | DOB (YYYY / MM / DD)

HEALTH CARD (OHIP) # | SEX

EMAIL | PRIMARY PHONE

ADDRESS

AFFIX PATIENT ID LABEL HERE

REFERRING PHYSICIAN

PHYSICIAN NAME | BILLING / OHIP # | PHONE | FAX

SIGNATURE | DATE

REFERRAL TYPE

(Select all that apply)

☐ Consult ☐ Gastroscopy ☐ Colonoscopy ☐ Sigmoidoscopy

REASON FOR REFERRAL

RELEVANT HISTORY, MEDICATIONS & ALLERGIES

(Please attach CPP if available)

☐ Pregnancy ☐ BMI > 40 ☐ Home O_2 / severe COPD ☐ Severe liver / kidney disease ☐ Dialysis ☐ Wheelchair bound

MEDICAL HISTORY

☐ COPD
☐ CHF/CAD/Stroke
☐ Bleeding disorder
☐ Pacemaker/ICD

MEDICATIONS

☐ Anticoagulant: _____
☐ ASA / NSAIDs
☐ Insulin / oral hypoglycemic

ALLERGIES

Please note that we will triage the referrals and provide the requested care at the appropriate location.
Patients will be informed if they will have their procedure or consultation in hospital or at The GUT Centre with one of our physicians.

Thank you for your referral. Please affix patient label or complete demographics in full.

Last Updated: 2026.08.19