



Gastric Diagnostic Assessment Program

PLEASE COMPLETE AND FAX REFERRAL FORM TO (416) 756 - 6832

| | | |
|--------------------|-------------|--------------|
| Last Name: | First Name: | DOB: |
| Health Card #: | Version: | Gender: |
| Address: | City: | Postal Code: |
| Preferred Phone #: | | |

| |
|---|
| Reason for Referral |
| <input type="checkbox"/> Diagnosed Gastric Cancer <input type="checkbox"/> Abnormal CT imaging results <input type="checkbox"/> Endoscopic/biopsy findings proven gastric cancer |
| <input type="checkbox"/> Symptoms highly suspicious for gastric cancer <input type="checkbox"/> Unexplained iron-deficiency anemia <input type="checkbox"/> Suspicious weight loss <input type="checkbox"/> Early satiety <input type="checkbox"/> Recurrent vomiting |
| Medical History and other pertinent information (e.g. allergies, medications, etc.): <div style="border: 1px solid black; height: 100px; width: 100%;"></div> |

Patient Informed of Diagnosis? _ Yes _ No

| | |
|---|--|
| Diagnostic Investigations - please attach ALL reports with referral if available. If not, we will arrange. | |
| Endoscopy performed: | <input type="checkbox"/> Date completed: _____ |
| Other Tests: | <input type="checkbox"/> MRI Scan Date completed: _____ <input type="checkbox"/> CT Scan Date completed: _____ <input type="checkbox"/> Ultrasound Date completed: _____ <input type="checkbox"/> Bloodwork Date completed: _____ <input type="checkbox"/> Pathology Date completed: _____ |

| | | |
|---|---------------------------------------|---|
| Referral Request | | |
| <input type="checkbox"/> Earliest appointment OR | | |
| <input type="checkbox"/> Dr. Usmaan Hameed | <input type="checkbox"/> Dr. Simon lu | <input type="checkbox"/> Dr. Peter Stotland |

| | |
|------------------------------|-------------------|
| Physician Information | |
| Referring Physician: | Family Physician: |
| Billing #: | Billing #: |
| Phone #: | Phone #: |
| Fax #: | Fax #: |
| Referral Date: | |

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NOTE: Your patient **MUST** be aware of this referral and will be contacted by our patient navigator. The patient navigator can be reached at **(416) 756-6444 ext. 4409, (416) 575-6276** or **colorectal.navigator@nygh.on.ca**