NORTH YORK GENERAL
Making a World of Difference

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
☐ Diagnosed Gastric Cancer ☐ Abnormal CT/ Ultrasound imaging results ☐ Endoscopic/biopsy findings proven gastric cancer
☐ Symptoms highly suspicious for gastric cancer ☐ Unexplained iron-deficiency anemia ☐ Suspicious weight loss ☐ Early satiety ☐ Recurrent vomiting
Medical History and other pertinent information (e.g. allergies, medications, etc.):

Patient Informed of Diagnosis? _ Yes _ No

Diagnostic Investigations - please attach ALL reports with referral if available. If not, we will arrange.	
Endoscopy performed:	☐ Date completed: _____
Other Tests:	☐ MRI Scan Date completed: _____ ☐ CT Scan Date completed: _____ ☐ Ultrasound Date completed: _____ ☐ Bloodwork Date completed: _____ ☐ Pathology Date completed: _____

Referral Request	
☐ Earliest appointment OR	
☐ Dr. Usmaan Hameed	☐ 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 **gi.navigator@nygh.on.ca**