

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/ Ultrasound 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.):

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. 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**