HAMILTON ENDOSCOPY CENTRE

DR. H. FERGANI

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PATIENT DEMOGRAPHICS:

First Name: _____ Last Name: _____

D.O.B.: _____ OHIP: _____Expiry Date_____

Address: _____Province: _____

Postal Code: _____Phone Number: _____

☐ **Symptomatic** ☐ **Positive FIT (Fecal Immunochemical Test)**

☐ **Family history of Colon Cancer**

REASON FOR REFERRAL:

_____

_____

_____

_____

_____

LIST OF CURRENT MEDICATIONS:

1._____ 5. _____

2._____ 6. _____

3._____ 7. _____

4._____ 8. _____

HEIGHT: _____ WEIGHT: _____ MOBILITY ISSUES: _____

REFERRING DOCTOR: _____

BILLING #: _____

ADDRESS: _____

PHONE #: _____ **FAX #:** _____