REFERRAL FORM ADULT CELIAC DISEASE CLINIC

MCMASTER UNIVERSITY

DATE OF REFERRAL ______________________

☐ FIRST AVAILABLE ☐ URGENT ☐ NOT URGENT

PATIENT INFORMATION

NAME ______________ LAST NAME ______________

ADDRESS ______________ CITY ______________ POSTAL CODE ______________

DATE OF BIRTH ______________ SEX ☐ F ☐ M

TELEPHONE ______________ CELLPHONE ______________

HEALTH CARD ______________

FAMILY DOCTOR ______________ PHONE ______________

FAX ______________

FILL IN OR PLACE FULL STICKER

PLEASE ENCLOSE COPY OF TESTS REPORTS

REASON FOR REFERRAL:

PAST MEDICAL HISTORY:

CURRENT MEDICATIONS:

COMMENTS:

REFERRING PHYSICIAN

REFERRING PHYSICIAN ______________ BILLING NUMBER ______________

FAX ______________

CELIAC DISEASE DIAGNOSIS

Date Of Celiac Disease Diagnosis (mm/dd/yyyy): ______________

Institution Of Celiac Disease Diagnosis: ______________

Date Of Duodenal Biopsies For Celiac Disease Diagnosis: ______________

Date Of Celiac Disease Specific Serology: ______________

(Please Attach Copy Of Endoscopy/ Pathology And Laboratory Reports)

PLEASE COMPLETE THE FORM AND FAX IT TO: 905-526-0594 / ATTN: Dr. M Ines Pinto-Sanchez