WELL Health
Hemorrhoid Treatment Centres

www.weallhealthhtc.com
T: 437-916-9128
F:1-437-800-4850

Physician Referral Form

Date of Referral	**Patient Details**
Date of Referral_____ yyyy/mm/dd	Name:
	Health Card:
	DOB:
	Phone:
	Email:
	Address:

Please Confirm Preferred Location:

☐ North York ☐ Mississauga

Reason for Referral/Presenting Issues:

☐ Hemorrhoids

☐ Rectal Bleeding

☐ Rectal Pain

☐ Anal Fissure

☐ Other (please specify)_____

Has the patient had a Colonoscopy within last 5 years? Yes ☐ No ☐

Has the patient had a Fecal Occult Blood Test within last 5 years? Yes ☐ No ☐

Please fax us the following information:

☐ Completed referral form

☐ Most recent Colonoscopy (if applicable)

☐ Most recent FOBT result

☐ Past medical history

Referred by:

Physician_____ Billing #_____

Address_____ Phone #_____

FAX REFERRAL TO: 1-437-800-4850

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Unit 226
North York, ON
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