

The Clinic
At Beverly Hills
Phone: 416-630-1712 / 647-352-3233
Fax: 416-630-6415

	Information
Name:	
DOB:	
	Tel. No.
	o.:
Referri	ng Physician Information
Referri	ng Physician:
	an Tel No:

Healthcare theclinicatbeverlyhills							P No.:	
TCBH Physician Name :				No Preference		Referring Physician Information Referring Physician: Physician Tel. No: Physician Fax No: Physician Billing No:		
Reason for	Referral (Please check all t	hat apply)						
	Gastroscopy			C	olonoscopy		Urology	
	Abdominal Pain		Abdominal Pain			Benign Prostatic Hyperplasia (Rezum/iTind)		
	Anemia		Anemia					
	Vomiting Dysphagia		Bloating/Gas Blood in Stool			 Bulkamid 		
				Colon Screening (50+)			 Radiofrequency 	
			Change in Bowel Habits			, , ,		
			History of Polyps			,		
	Diarrhea		Weight Loss Family History FIT (+)			Circumcision (Newborn/Pediatric/Adults)		
	Other (Please specify):							
_								
_					Please Specify):		 NanoKnife Robotics Surgery 	
							Other (Please Specify):	
	Weight Loss			R	apid Assessment		Other Services	
	Weight Management		Prostate Clinic			Endo Venous Laser		
	Nutrition Counselling		Hemorrhoid Treatment Clinic			Treatment (EVLT)		
	Gastric Balloon			0	Transanal Hemorrhoi	idal \square	Varicose Vein Ligation	
				0	Dearterialization ELITE Laser Hemorrho RBL	oidoplasty \Box	IBS Testing	
Medical Hi	story (Please check all that	apply):			Additional Note	25:		
	Heart Disease		Diabetes					
	Sleep Apnea		Asthma/CO	PD				
	Other (Please Specify):							
					-			
Allergies: .					Medications:			