MOUNT SINAI HOSPITAL
Joseph and Wolf Lebovic Health Complex
600 University Avenue
Toronto, Ontario, Canada M5G 1X5

Form C 23 (05.2013)

Clearly Imprint Patient Identification

Mount Sinai Hospital IBD Center
IBD Consultation Request

Request Date: (YYYY MM DD) _____

Please complete all fields for this referral to be processed

Referring Physician Information

Name: _____
OHIP Billing # _____
Address: _____
_____
Phone: _____
Fax #: _____
Signature: _____

Patient Information

Last Name: _____
First Name: _____
Address: _____
_____
DoB: _____
Health Card # _____
V. Code _____
Gender ☐ **Female** ☐ **Male**
Phone (H) _____ **Phone (C)** _____
Email Address: _____

Referral to (please check one)

☐ First available appointment ☐ Dr. G. Nguyen ☐ Dr. K. Croitoru
☐ Dr. M. Silverberg ☐ Dr. H. Steinhart ☐ Dr. A. Weizman

Reason for referral (check all that apply)

☐ Diagnosis of IBD
☐ Assume ongoing IBD management
☐ Second Opinion (Please provide specific question or issue)

Referral Priority (check one)

☐ Urgent* (within 14 days) _____
☐ Expedited (within 1 month)
☐ Standard (up to max 3 months)

We endeavor to see new referrals as quickly as possible based upon their degree of urgency. For urgent referrals, please provide a brief overview of the reason for the urgency of the request*.

Diagnosis: CD ☐ UC ☐ Indeterminate Colitis (IBDU) ☐ Suspected IBD ☐
Disease Location _____

Please provide copies of the following information with referral

☐ Recent imaging results
☐ Blood work
☐ Endoscopy and Surgical Reports

Current medications and doses
1. _____
2. _____
3. _____
4. _____
5. _____

Past Surgical Procedures
1. _____
2. _____
3. _____
4. _____

IBD CENTER USE ONLY

Date Received: (YYYY MM DD)	Date Processed (Patient Contact Date): (YYYY MM DD)	Next Available Date: (YYYY MM DD)	
		Procedure Date: (YYYY MM DD)	Time: (HH : MM)
		Scheduled By:	

EMAIL COMPLETED FORM TO ibdreferrals@mtsinai.on.ca