GI Investigation Unit
East Wing, 4th Floor
399 Bathurst St. Toronto, ON
Tel: 416 603-5356
Fax: 416 603-5783

Referral Form for Anorectal Manometry

Patient Name:_____

Email: _____

Sex: **M/F** **DOB (D/M/Y):** _____

Referring Doctor: _____

Phone#: _____ **Fax#:** _____

Family Doctor: _____

Date: _____

Patient demography: address, phone #, OHIP, MRN(if known)

PRIMARY REASON OF REFRRAL:

- ☐ Fecal incontinence
- ☐ Constipation
- ☐ Rectal pain
- ☐ Other:
  Specify: _____

Pre-Treatment:

- ☐ Pre-sphincter repair
- ☐ Pre-anastamosis sphincter assessment

Primary Symptoms:_____

_____

Background and related symptoms:_____

_____

Specific question being asked: _____

_____

(For external use only)