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## **Endoscopic Ultrasound (EUS) Referral Form**

Date:	I	Referring MD:	
Patient Information (affix	( label): 		
<u>Urgency:</u> □ Urgent (<2 weeks)	  □ Moderate (2	2-8 weeks)   Rout	
Reason for Referral:			
Please include: Releva and a current medicati		diagnostic imaging (ultras referral.	ound, CT, MRI)
Please also indicate if yo	our patient is takir	ng the following:	
Insulin:	□ Yes □ No	Oral anticoagulants:	□ Yes □ No
Oral Hypoglycemics:	□ Yes □ No	If yes, name of medication:	

Please fax completed form and relevant documents to 416-340-5324.