Sinai Health System

PACE
ADVANCING PATIENT CARE BY CROHN'S AND COLITIS CANADA

Telemedicine IBD Consultation Request
Mount Sinai Hospital IBD Centre
600 University Avenue – 4th Floor
Toronto, Ontario, M5G 1X5
paceibd.msh@sinaihealthsystem.ca

Patient Information

Last Name
First Name
Address

Health Card # Version Code
Phone (H) Phone (C)
Email Address
DoB Gender ☐ Female ☐ Male

To be processed, please complete all fields on this referral form

Referring Physician or NP Information
Name
OHIP Billing #
Address

Phone Fax
Signature
Request Date (YYYY MM DD)

Referral to: (check one)
☐ First available appointment
☐ Dr. G. Nguyen ☐ Dr. K. Croitoru
☐ Dr. M. Silverberg ☐ Dr. H. Steinhart
Dr. Sun-Ho Lee
☐ Dr. Gallinger
☐ Dr. Huang
☐ Dr. A. Weizman

Preferred OTN site (if known):

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 3 months)

Note: We endeavor to see patients as quickly as possible based on their degree of urgency. For urgent referrals*, please provide a brief overview to support the urgent request:

Diagnosis: ☐ Crohn's Disease ☐ Ulcerative Colitis ☐ IBD - unclassified ☐ Suspected IBD

Disease Location:

Please provide copies of the following information with the referral:

☐ Recent Imaging Results ☐ Endoscopy or Surgical Reports ☐ Blood Work

Current Medications and Doses

1.
2.
3.
4.
5.

Past IBD Surgical Procedures

1.
2.
3.
4.
5.

IBD CENTRE USE ONLY		
Date Received (YYYY MM DD)	Next Available Date (YYYY MM DD)	Scheduled by:
Date Processed / Patient Contact Date (YYYY MM DD)	Appointment Date (YYYY MM DD)	Appointment Time: HH: YYYY MM DD

FAX or EMAIL COMPLETED FORM TO: 416-586-5971 or paceibd.msh@sinaihealthsystem.ca