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FRCSC, General Surgeon

# SOUTH ISLAND HEMORRHOID CLINIC

## Minor Surgical Procedures

101-9717 Third Street, Sidney, B.C V8L 3A3  
**Phone:** 250-656-8121 **Fax:** 250-656-8014  
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**Website:** southislandhemorrhoidclinic.com

### HEMORRHOID REFERRAL FORM

#### REFERRING PROVIDER

Name: \_\_\_\_\_  
Clinic Name: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
Billing Number: \_\_\_\_\_

#### PATIENT DEMOGRAPHICS

Patient Name: \_\_\_\_\_  
DOB: \_\_\_\_\_ PHN:| \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_ Cell: \_\_\_\_\_  
Email: \_\_\_\_\_

#### REASON FOR REFERRAL

Hemorrhoids  Rectal bleeding  Anal pain  Prolapse  
 Other: \_\_\_\_\_

#### PAST INVESTIGATIONS (please attach if applicable)

Colonoscopy (date): \_\_\_\_\_  Flexible Sigmoidoscopy  
 Labs  None  Other \_\_\_\_\_

#### RELEVANT MEDICAL HISTORY

**Anticoagulants**  Bleeding disorder  
 Other: \_\_\_\_\_

Patient is aware of and consents to this referral

Referring Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_