Patient's last name	First name	
Address-Street	City	Postal code
Telephone ( )	Ext	
Date of birth (yyyy/mm/dd)	Age	Gender M F
HIN	Family physician	

PATIENT REFERRAL FORM- ADULT CELIAC DISEASE CLINIC MCMASTER UNIVERSITY

DATE OF REFERRAL: DD/MM/YYYY________/______/__________

DATE OF CELIAC DISEASE DIAGNOSIS (MM/YYYY):______________/__________
INSTITUTION OF CELIAC DISEASE DIAGNOSIS:____
DATE OF DUODENAL BIOPSIES FOR CELIAC DISEASE DIAGNOSIS:________________/___________
DATE OF CELIAC DISEASE SPECIFIC SEROLOGY:____________/_____________________________
(PLEASE ATTACH COPY OF ENDOSCOPY/ PATHOLOGY AND LABORATORY REPORTS)

REASON FOR REFERRAL:

PAST MEDICAL HISTORY:
1-
2-
3-
4-
5-
6-
7-
8-

CURRENT MEDICATIONS
1-
2-
3-
4-
5-
6-
7-
8-

COMMENTS:

PLEASE COMPLETE THE FORM AND FAX IT TO: 905-526-0594 / ATTN: Dr. M Ines Pinto-Sanchez

PLEASE ENCLOSE COPY OF TESTS REPORTS