

**Patient Information**

Label Here

**Referring Physician**

Date : \_\_\_\_\_  
Physician Name: \_\_\_\_\_  
Physician Address: \_\_\_\_\_  
Physician Number: \_\_\_\_\_  
Physician Signature: \_\_\_\_\_  
Copies to: \_\_\_\_\_

# Gut Health Clinic

**Check ALL symptoms that apply**

- Abdominal Pain or Discomfort
- Abdominal Cramps or Spasms
- Abdominal Bloating and Distention
- Abnormal or Irregular Bowel Movements
- Anxiety
- Depression
- Belching
- Combination of both Diarrhea and Constipation
- Constipation
- Diarrhea
- Flatulence
- Fatigue
- Foul-Smelling Stools
- Food Intolerances or Sensitivities
- Gastrointestinal Reflux (Heartburn)
- Increased Sensitivity to Stress
- Loss of Appetite
- Mucus in the Stool
- Muscle Pain or Stiffness
- Nausea
- Poor Sleep Quality
- Sleep Disturbances (Insomnia)
- Urgency to have a Bowel Movement
- Weight Fluctuations

**Please include ALL relevant investigational reports and consultation notes, including Blood and Stool tests, Ultrasound, X-rays, Endoscopy/Colonoscopy, CT and/or MRI.**

**Clinical Notes:**

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**Please fax completed form - we will call the patient to book.**