Mount Sinai Hospital
Sinai Health System
Joseph & Wolf Lebovic Health Complex

SCHWARTZ/REISMAN
EMERGENCY CENTRE

PATIENT LABEL

General Surgery Referral Form
Suspicious Mass/Lesion

Date of Emergency Visit: _____

Reason for Referral:

- □ **Colorectal lesion**
- □ **Gastric lesion**
- □ **Possible abdominal sarcoma**

Clinical Information:

Patient Instructions:

- You will be contacted for an appointment
- Please call 416-586-4800 x 6872 if you haven't heard about an appointment within 7 business days of your emergency visit

Referring Physician Information:

Referring ED Physician: _____

Billing #: _____

Please fax this referral form and ED chart to:
Dr. Erin Kennedy, Fax: 416-586-8644