

Paul Frydrych

Weston

2050 Weston Rd Toronto ON M9N 1X4

Tel: 416-763-1171 Fax: 416-763-0573

Consultation Request

Date:	2025-10-23	Patient:	WALLACE, LINDA
Status:	Non-Urgent	Address:	39 Belvedere Blvd Etobicoke, ON, M8X 1K3
Service:	Endocrinology	Phone:	416-239-3379
Consultant:	LMC Etobicoke, Dr. Adel Hanna	Work Phone:	
Phone:	416-645-1035	Cell Phone:	
Fax:	416-645-1036	Email:	lwallace039@gmail.com
Address:	Dr. Adel Hanna Suite 2B - 1723 Kipling Ave Etobicoke, ON M9R 4E1	Birthdate:	1960-08-17 (y/m/d)
		Sex:	F
		Health Card No.:	(ON) 9765976379 EK
		Appointment date:	
		Time:	
		Chart No.:	

Reason for consultation:

#Hyponatremia - ongoing refer to endocrinology for workup

Pertinent Clinical Information:

#Recurrent Vertigo - Mild SNHL on L 5/2025, probably peripheral vestibulopathy reduced response on L side, BPPV + on L in VNG #Varicose Veins #HTN - good control on ramipril per ambulatory BP Dr P Mitoff 4/2022 monitor ambulatory q1-2 years #Psoriasisiform Dermatitis - Dr R Alhusayen 8/2021, planning phototherapy, clobetasol, Protopic to face, consider patch testing #Mild Neutropenia - monitor #Cervical Radiculopathy - L arm hypesthesia - MRI 11/2020 confirms multilevel DDD and significant neuroforaminal narrowing #Abnormal Breast US - probably stable nodules bilaterally - BIRADS 3 8/2020 6 month followup delayed due to COVID - 6/2021 Stable benign-appearing subcentimetre findings at 4 o'clock in the left breast and 9 o'clock in the right breast. The benign-appearing finding at 11 o'clock in the right breast measures slightly larger in one dimension compared to the previous ultrasound, although the minor size discrepancy could be technical in nature. Follow-up of all three lesions with targeted breast ultrasound is recommended 12/2021 and mammogram due 8/2021 - stable 1/2024 #L Arm Hypesthesia - brachial plexus wnl 8/2020 but needs repeat c-spine MRI #Secondary Hyperparathyroidism - 2/2 to vitamin D deficiency Dr Monteiro ENT 1/2020 PTH 7/1 Ca 2.3 Vit D 8.3 #Chronic Upper Back Pain - in location of kyphosis / erector spinae/paraspinal muscles, ddx DDD, myofascial pain unlikely radicular or neuropathic type given exam and hx - trial Tylenol 500-1000 mg TID PRN, may try robaxacet caution re: fatigue - if this fails consider PREGABALIN particularly given comorbid anxiety - may need accessible parking permit if refractory to treatment - pt to continue daily exercise, PT #Depression/Anxiety - seeing psychiatrist at Aberfoyle Clinic Dr Morris qmonth visit, was stressed trying to move to new position, sick leave, SJH - day program a few years ago, meditation classes through SJH and WCH, CBT program at SJH, no SA #Chronic Eczema #IBS-C - since 30's #Mild Cognitive Impairment - Toronto Memory Clinic at least since 2014, was stable 7/2019 #Hyperlipidemia - FRS 8.9% LDL 2.19 8/2023 #Hypothyroidism - dx since 30's, thyroid nodules Dr Brionus at WCH 2018 #Osteoporosis - kyphosis dx 2015, had elevated parathyroid hormone, low vitamin D, was told to replete vitamin D, VFA no compression fractures, DDD 11/2019, plan for BMD 8/2020

Current Medications:

FLUOXETINE 20 MG CAPSULE Week 1-2: 1 capsule PO qAM Week 3-4: 2 capsules PO qAM Qty:60 CAPSULE Repeats:1

RAMIPRIL 5 MG CAPSULE TAKE 1 CAPSULE EVERY MORNING Qty:100 Capsule(s) Repeats:1

VAGIFEM 10 10 MCG VAGINAL TAB 1 PV QHS for 14-Days. Then 1 PV Twice Weekly . Qty:24

TABLET Repeats:3

TABLET Repeats:3

ROSUVASTATIN 5MG TABLET 2 tablet PO qHS Qty:200 tablet Repeats:3

AMLODIPINE 5 MG TABLET 1/2 tablet PO qHS per Dr Mitoff Qty:50 tablet Repeats:3

SERC 24 MG TABLET 1/2-1 tablet PO TID PRN severe dizziness Qty:30 TABLET Repeats:2

CICLESONIDE 50 MCG NASAL SPRAY 1 spray each nostril daily for 2-4 weeks Qty:1 SPRAY,

NON-AEROSOL Repeats:5

LEVOOTHYROXINE SODIUM 75MCG TABLET 1 tablet PO daily on Monday/Wednesday/Friday

Qty:39 tablet Repeats:3

LEVOOTHYROXINE SODIUM 50MCG TABLET 1 tablet PO Tuesday/Thursday/Saturday/Sunday

Qty:52 tablet Repeats:3

AG-VITAMIN B12 1,000 MCG TAB 1 tablet PO qday for 3 months then recheck Qty:100 Repeats:3

Allergies:

ALCOHOL - Mild Allergy - Reaction: white wine - arrhythmia

MONUROL - Mild Allergy - Reaction: bloody diarrhea

Referring Practitioner : Paul Frydrych MD (030595)

MRP : Frydrych, Paul (030595)

Requesting Physician : Paul Frydrych MD (030595)

Signature:





TORONTO IMMUNE & DIGESTIVE HEALTH INSTITUTE

03-Oct-2025

Dr. Paul Frydrych
2050 Weston Road
Toronto, ON M9N 1X4

Patient: Ms. Linda Wallace
PHN: 9765 976 379EK
Birthdate: 17-Aug-1960
Phone: H: (416) 239-3379 C: (416) 239-3379
Address: 39 Belvedere Blvd
Etobicoke, ON M8X 1K3

Dear Dr. Frydrych,

Thank you for referring Ms. L. Wallace who was seen in consultation in the Toronto Immune and Digestive Health Institute Inc. (TIDHI) on October 6, 2025.

Linda is a 65-year-old female referred for evaluation of worsening abdominal pain.

HISTORY OF PRESENTING ILLNESS

Ms. Linda Wallace, a 65-year-old woman, presents with a longstanding history of abdominal pain that has recently worsened.

She reports that her symptoms began acutely after returning from a trip to Vancouver in early August. At that time, she noticed new-onset abdominal bloating and persistent, crampy lower abdominal pain, which she describes as similar to menstrual cramps, despite being postmenopausal. The pain initially involved the lower abdomen and was most pronounced in the right lower quadrant, at times raising concern for appendiceal involvement. The discomfort was continuous upon her return but has since become intermittent, with some improvement following dietary modifications.

She describes her baseline bowel pattern as chronically abnormal, with daily bowel movements of loose or mushy, consistent with her longstanding diagnosis of irritable bowel syndrome (IBS). She denies any recent changes in bowel frequency, consistency, or urgency. There is no reported constipation, diarrhea, hematochezia, melena, or mucus.

She denies any upper gastrointestinal symptoms such as nausea, vomiting, heartburn, regurgitation, or dysphagia. She does not report any burping or significant flatulence. There is no history of GI bleeding.

Associated symptoms include a sensation of bloating and, at times, a film or sand-like residue on her tongue and in the water after brushing her teeth.

She also notes a mild decrease in appetite and reports an unintentional weight loss of approximately 10 pounds over a short period (within the past month), dropping from 150 pounds to 135 pounds. She denies fevers, night sweats, or other constitutional symptoms. She reports increased anxiety, particularly in medical settings, which has resulted in labile hypertension with systolic readings up to 200 mmHg during periods of stress.

She underwent a colonoscopy at age 50 due to a family history of colonic polyps and colon cancer (her father has recurrent polyps and her paternal uncle died of colon cancer). The procedure was reportedly unremarkable; she tolerated the bowel preparation (Pico-Salax) well. Since then, she has not had repeat colonoscopy but has completed annual fecal immunochemical tests (FIT), all of which have been negative. She has not had prior upper endoscopy.

Following the onset of her current symptoms, an abdominal and pelvic ultrasound (including endovaginal study) was performed on August 19, 2025, which revealed bilateral non-obstructing

renal calculi (7 mm and 6 mm), a small uterine fibroid, and a possible endometrial cyst. The right lower quadrant was obscured, possibly due to gas or stool, and the appendix was not visualized. No bowel wall thickening or free fluid was identified. She has not had any further imaging since then.

She visited a walk-in clinic where a palpable mass was noted in the lower abdomen; the etiology was unclear, and the mass was thought possibly to represent stool.

She has a history of multiple allergies and intolerances, including a reaction to Monurol (fosfomycin) and a remote episode of delayed emergence from anesthesia during wisdom tooth extraction, though the specific agent is unknown. She is concerned about potential allergic reactions to sedation agents such as propofol, which she has never previously received.

She has trialed dietary modifications for IBS, including avoidance of cauliflower, broccoli, and dairy, and has increased her water intake. She consumes oatmeal, blueberries, and coffee daily, and previously ingested a few almonds daily for calcium supplementation due to dairy avoidance. She takes vitamin D supplementation (5,000 IU daily). She reports some improvement in symptoms with these dietary changes but continues to experience intermittent lower abdominal discomfort.

She denies any family history of inflammatory bowel disease (IBD) or celiac disease. There is no family history of colorectal cancer (CRC) in first-degree relatives, but there is a paternal uncle who died of colon cancer and a father with recurrent colonic polyps.

She denies smoking, alcohol use, and illicit drug use.

She reports no prior surgeries and has not had any hospitalizations.

She has a history of osteoporosis, nephrolithiasis, hypertension, hyperlipidemia, hypothyroidism, thyroid nodules, kyphosis, benign paroxysmal positional vertigo, left-sided sensorineural hearing loss, cervical radiculopathy and degenerative disc disease, mild cognitive impairment, depression, anxiety, psoriasisiform dermatitis, eczema, varicose veins, mild neutropenia, secondary hyperparathyroidism due to vitamin D deficiency, and breast nodules.

Red flags identified include unintentional weight loss of 10 pounds in one month and a palpable abdominal mass. There is no reported GI bleeding or anemia.

PAST MEDICAL HISTORY

Her past medical history is significant for irritable bowel syndrome with constipation, hepatic steatosis, hypertension, hyperlipidemia, hypothyroidism, thyroid nodules, osteoporosis, kyphosis, nephrolithiasis, uterine fibroid, endometrial cyst, benign paroxysmal positional vertigo, left-sided sensorineural hearing loss, cervical radiculopathy and degenerative disc disease, mild cognitive impairment, depression, anxiety, psoriasisiform dermatitis, eczema, varicose veins, mild neutropenia, secondary hyperparathyroidism due to vitamin D deficiency, and breast nodules. There is no history of IBD, celiac disease, or colorectal cancer in first-degree relatives.

MEDICATIONS

Current medications include ramipril 5 mg orally every morning, amlodipine 2.5 mg orally at bedtime, rosuvastatin 10 mg orally at bedtime, levothyroxine sodium 75 mcg orally and vitamin B12 1000 mcg orally daily. She also takes vitamin D 5,000 IU daily.

ALLERGIES

Allergic to Monurol (fosfomycin). She reports intolerance to certain anesthetics (delayed emergence from anesthesia during wisdom tooth extraction, agent unknown). Multiple food intolerances/allergies, specifics not fully documented.

SOCIAL HISTORY

Ms. Wallace is a non-smoker and does not consume alcohol.

She reports significant anxiety, particularly in medical settings, which exacerbates her hypertension.

FAMILY HISTORY

Her father has recurrent colonic polyps. Her paternal uncle died of colon cancer. No family history of IBD or celiac disease. No colorectal cancer in first-degree relatives.

PHYSICAL EXAM

Ms. Wallace appears well and in no acute distress. Abdominal examination reveals a soft abdomen with mild tenderness and a palpable mass in the right lower quadrant. At a recent walk-in clinic visit, a palpable mass was noted in the lower abdomen, etiology unclear (possibly stool).

No guarding, rebound, or peritoneal signs. No hepatosplenomegaly.

LAB AND IMAGING RESULTS

Laboratory investigations from October 2, 2024, show hemoglobin 131 g/L, mean corpuscular volume (MCV) 92 fL, white blood cell count $4.1 \times 10^9/L$, lymphocyte count $1.7 \times 10^9/L$, neutrophil count $1.7 \times 10^9/L$ (low), platelet count $214 \times 10^9/L$, creatinine 63 mol/L, sodium 133 mmol/L (low), potassium 4.6 mmol/L, and ferritin 79 g/L. Lipid profile from May 7, 2025: total cholesterol 3.72 mmol/L, LDL cholesterol 2.06 mmol/L, non-HDL cholesterol 2.31 mmol/L, HDL cholesterol 1.41 mmol/L, cholesterol/HDL ratio 2.6, triglycerides 0.48 mmol/L.

Abdominal and pelvic ultrasound including endovaginal study on August 19, 2025: Grade 1 hepatic steatosis; gallbladder and bile ducts unremarkable (CBD 4 mm); pancreas unremarkable; bowel and peritoneal spaces: no free fluid, no thickened loops of bowel. Bilateral non-obstructing renal calculi; no abdominal masses of concern; incidental submucosal uterine fibroid; possible small endometrial cyst or cystic hyperplasia. Right lower quadrant was obscured, possibly due to gas or stool; appendix not visualized.

Ultrasound KUB on March 25, 2024: No significant findings.

Abdominal ultrasound on January 25, 2024: No cause for abdominal pain identified.

MRI cervical spine (November 2020): Multilevel degenerative disc disease and significant neuroforaminal narrowing.

Annual FIT tests have been negative.

IMPRESSION

1. Chronic lower abdominal pain with recent worsening, unintentional weight loss, and palpable lower abdominal mass-red flags for possible underlying colonic neoplasm or other intra-abdominal pathology, particularly in the context of family history of polyps and colon cancer.
2. History of irritable bowel syndrome with chronic loose stools and bloating-symptoms may overlap but do not explain new red-flag features.

PLAN

- Given the presence of red-flag symptoms (recent unintentional weight loss, palpable abdominal mass, family history of colon cancer and polyps), urgent further evaluation is warranted. I recommend proceeding with a colonoscopy to evaluate for colonic neoplasm, mass, or other pathology.
- Given the patient's significant anxiety regarding procedural sedation and her preference for a hospital-based setting, I will refer her to Dr. Tandon at Toronto Western Hospital for colonoscopy.
- I will also order a CT scan of the abdomen and pelvis without intravenous contrast (due to reported allergy concerns) at Mount Sinai Hospital to further evaluate the palpable mass and to clarify the findings in the right lower quadrant, which was obscured on prior ultrasound. If the colonoscopy is non-diagnostic or if further characterization is required, a contrasted CT may be considered with premedication as appropriate, balancing the risks of steroid use in the context of her osteoporosis.
- Continue current dietary modifications for IBS and maintain adequate hydration. Reinforce avoidance of dietary triggers as identified. No changes to current medication regimen at this time.

FOLLOW-UP

Follow-up will be coordinated with Dr. Tandon at Toronto Western Hospital for colonoscopy. I will arrange for a CT abdomen/pelvis without contrast at Mount Sinai Hospital. Reassessment in clinic after completion of investigations or sooner if symptoms worsen.

Thank you for involving me in the care of this patient.

CONSENT & COMPLIANCE

Verbal informed consent was obtained from the patient for audio recording the clinical encounter with the Scribeberry platform which converts the conversation to a script by using AI. The conversations are transcribed simultaneously in real time and no audio recordings are stored. The notes from the appointment are saved and are added to the Electronic Health Record, as standard. Scribeberry platform complies with all applicable standards and regulations for the handling of personal health information, including the Personal Information Protection and Electronic Documents Act (PIPEDA),

Canada).

Sincerely,



Petros Zezos, MD

Electronically Reviewed to Expedite Delivery

Patient: LINDA MARIE WALLACE | Health Number: 9765 976 379

Ministry of Health and Long-Term Care
Ontario Laboratories Information System (OLIS)

Generated from OLIS on 2025-10-23 15:37:32 by user Paul Frydrych

Patient	Provider	Report Details	
Ontario Health Number: 9765 976 379	Ordered By: FIEGHEN, HEATHER ELIZABETH	Report Status: Final	
Medical Record Number: 103247657	MD #: 86865	Order Id: 74664608	St. Joseph's Health Centre (Lab 4145)
Patient Name: LINDA MARIE WALLACE	Address: 30 THE QUEENSWAY M6R 1B5, TORONTO, ON, CAN	Order Date: 2025-10-18	
Date of Birth: 1960-08-17	Work Number: (416) 530-6084	Last Updated In OLIS: 2025-10-18 08:55:35 EDT	
Age: 65 years	Attending Provider: ELSOBKY, REEM AHMED	Specimen Received:	2025-10-18 08:50:33 EDT (unless otherwise specified)
Sex: F	MD #: 85645	Ordering Facility:	St. Joseph's Health Centre (Lab 4145)
Home Address: 39 BELDEVERE BOULEVARD M8X 1K3 ETOBICOKE, ON CAN	Admitting Provider: FIEGHEN, HEATHER ELIZABETH	Address:	30 The Queensway M6R 1B5 Toronto, ON CAN
Home:	MD #: 86865	Performing and Reporting Facility:	St. Joseph's Health Centre (Lab 4145)
Telephone: (416) 239-3379 Primary Residence Number		Address:	30 The Queensway M6R 1B5 Toronto, ON CAN
Work:			

Report Comments:**Hematology**

Specimen Type	Collection Date/Time	Specimen Collected By		
Blood venous	2025-10-18 08:32:00 EDT	St. Joseph's Health Centre (Lab 4145)		
Test Name(s)	Result	Abn	Reference Range	Units
Complete Blood Count (Final)				
Leukocytes; Blood	4.6		4.0-11.0	x10 ⁹ /L
Erythrocytes; Blood	4.39		3.80-5.20	x10 ¹² /L
Hemoglobin; Blood	135		115-155	g/L
Hematocrit; Blood	0.38		0.37-0.48	L/L
Mean Corpuscular Volume; RBC	86		82-97	fL
Mean Corpuscular Hemoglobin; RBC	30.8		27.0-32.0	pg
Mean Corpuscular Hemoglobin Concentration; RBC	356		320-360	g/L
Erythrocyte Distribution Width; RBC	11.8		11.7-14.4	%
Platelets; Blood	262		140-400	x10 ⁹ /L
Mean Platelet Volume; Blood	9.8		9.4-12.3	fL
Result Status	Yes			
Neutrophils; Blood	2.4		2.0-6.3	x10 ⁹ /L
Lymphocytes; Blood	1.4		1.0-3.2	x10 ⁹ /L
Monocytes; Blood	0.7		0.2-0.8	x10 ⁹ /L
Eosinophils; Blood	0.1		0.0-0.4	x10 ⁹ /L
Basophils; Blood	0.0		0.0-0.1	x10 ⁹ /L
Granulocytes Immature	0.0		0.0-0.1	x10 ⁹ /L
Erythrocytes nucleated/100 leukocytes; Blood	0			/100 WBCs
Differential Cell Count Method	Auto			

CC List

Name: FIEGHEN, HEATHER ELIZABETH	Name: FRYDRYCH, PAUL AVRAM
MD #: 86865	MD #: 102345

Patient: LINDA MARIE WALLACE | Health Number: 9765 976 379
Ministry of Health and Long-Term Care
Ontario Laboratories Information System (OLIS)

Generated from OLIS on 2025-10-23 15:37:32 by user Paul Frydrych

Ordering Facility	Admitting Provider	Attending Provider
St. Joseph's Health Centre (Lab 4145) Address: 30 The Queensway M6R 1B5, Toronto, ON, CAN	Name: FIEGHEN, HEATHER ELIZABETH MD #: 86865	Name: ELSOBKY, REEM AHMED MD #: 85645



Patient: Wallace, Linda Marie
MRN: 1192333, DOB: 17/8/1960, Legal Sex: F

Progress Notes by Tandon, Parul, MD at 20/10/2025 11:15 AM

Author: Tandon, Parul, MD
Filed: 20/10/2025 10:16 AM
Editor: Tandon, Parul, MD (Physician)

Service: —
Encounter Date: 20/10/2025

Author Type: Physician
Status: Signed

Gastroenterology Progress Note

Date: 20/10/2025

65 year old woman who was referred to me for colonoscopy in-hospital from Dr. Zezos at TIDHI.

She has had longstanding abdominal pain, progressively worsening since trip to Vancouver, with bloating. Symptoms worse in the RLQ. She has loose to mushy Bms, no blood or melena. She reports no UGI symptoms. She has an unintentional weight loss of 10 lbs.

We were to perform a colonoscopy on Friday October 17th but unfortunately she was admitted to St. Josephs hospital with hyponatremia, dehydration, presumably from dehydration.

She tells me after drinking 1L of the BI-PEGLYTE, she had 5 loose Bms. She started to experience chest discomfort/tightness at which point she presented to the ED

Past Medical History: Osteoporosis, Kidney stones, HTN, DLD, Hypothyroidism, Thyroid nodules, BPPV, Sensorineural hearing loss, DDD, Depression, Anxiety, Psoriasisiform dermatitis, breast nodules

Meds: Ramipril, Amlodipine, Crestor, Synthroid, B12, D

Allergies: Fosfomycin.

Endoscopic HX

1. Colonoscopy at age 50 - unremarkable. Had PICO SALYX at that time.
2. Annual FITs since then which have been negative.

Family History

1. Paternal uncle - colon cancer
2. Father - polyps

Social History

1. Non smoker, no alcohol, no drug use.

Imaging

CT abdomen/pelvis Oct 3 2025

OPINION: Within limits of assessment on this CT tomogram, no definite cause for patient's symptoms identified. There is moderate fecal loading in the right and transverse colon.

Assessment and Plan

65F with GI symptoms, weight loss, and query palpable mass felt on exam by Dr. Zezos. She unfortunately developed significant hyponatremia and dehydration from the bowel preparaiton. I explained to her that the BI-PEGlyte is a isotonic solution and in itself should not result in hyponatremia. Alternative options such as PICO SALYX on the other hand have a real risk of leading to electrolyte imbalances.

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Patient: Wallace, Linda Marie
MRN: 1192333, DOB: 17/8/1960, Legal Sex: F

Progress Notes by Tandon, Parul, MD at 20/10/2025 11:15 AM (continued)

I also explained that even alternative options such as CT colonography would require a bowel prep and that her red flag symptoms do warrant a colonoscopy.

As such, I explained trying the bowel prep again but this time with adequate hydration, intake of oral rehydration electrolyte solutions, and perhaps doing the bowel preparation over 48hrs to minimize the acute volume losses. Though she should likely hold her ACEi, unfortunately, she has significant hypertension around medical environments and I worry that her BP may be an issue if we hold her anti hypertensives.

She has agreed to proceed with the following plan

1. Reduce free water intake on the week of her bowel prep
2. Buy oral rehydration solution with electrolytes and consume with bowel prep
3. Slower intake of BI-PEGLYTE

She also inquired if I could take over her GI care and unfortunately I cannot given my prolonged wait times. She will return to her GI care at the TIDHI clinic with Dr. Zezos once the colonoscopy has been completed

Parul Tandon DO PhD FRCPC
Gastroenterology, University Health Network
Clinician Scientist, Inflammatory Bowel Diseases
Office Phone: 416-603-5949 | Fax: 416-603-6204 | Email: twhgi@uhn.ca

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Patient: Wallace, Linda Marie
MRN: 1192333, DOB: 17/8/1960, Legal Sex: F

Progress Notes by Tandon, Parul, MD at 16/10/2025 10:45 AM

Author: Tandon, Parul, MD
Filed: 16/10/2025 9:53 AM
Editor: Tandon, Parul, MD (Physician)

Service: —
Encounter Date: 16/10/2025

Author Type: Physician
Status: Signed

I spoke to Linda today

Plan for tomorrow

1. No DULCOLAX due to lactose allergy
2. She will trial bi-peglyte
3. She can take her medications with apple sauce before 8am tomorrow.
4. I reminded her that her arrival time is 8am tomorrow

Parul Tandon DO PhD FRCPC
Gastroenterology, University Health Network
Clinician Scientist, Inflammatory Bowel Diseases
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