Thunder Bay Regional Health Sciences Centre

Endoscopy Services

SCREENING COLONOSCOPY REFERRAL

Place Patient Label with Barcode Here

Guidelines:

1. Physician to complete referral.
2. Fax to Endoscopy Services at 807-684-5859. Patient and Referring Physician will be contacted by Endoscopy with procedure date/time. Registered Nurse will also contact patient prior to procedure.
3. Completed referral forms will be filed on the patient's health record

QUESTIONS (?) – Contact Endoscopy 807-684-6184

INDICATION FOR SCREENING COLONOSCOPY ONLY

☐ PF - Patient (50-74yrs) referred after a positive FOBT(Fecal Occult Blood Test)
Date: _____

☐ FD – Patient (74yrs old or younger) referred first-degree relative had colorectal cancer
Specify relative: _____

ALL OTHER INDICATIONS FOR COLONOSCOPY NEED TO BE REFERRED DIRECTLY TO THE SPECIALIST'S OFFICE*

SCREENING COLONOSCOPY REQUESTED

☐ First Available Screening Appointment OR Preferred Colonoscopist:
☐ Dr. A. Alallam ☐ Dr. E. Davenport ☐ Dr. K. Gehman ☐ Dr. W. Harris ☐ Dr. M. Holmes ☐ Dr. J. Joanes
☐ Dr. G. Mapeso ☐ Dr. W. O'Hara ☐ Dr. K. Raman ☐ Dr. H. Telang

PATIENT INFORMATION

Last Name, First Name: _____ Date of Birth (day/month/year) _____
Sex: ☐ Female ☐ Male Health Card Number: _____ Version Code: _____
Address _____ Telephone: Home _____
_____ Work _____ Cell _____
Primary Contact (Last Name, First Name): _____
Relationship to Patient: _____ Phone Number: _____
☐ Patient incapable of giving his/her own Informed Consent
Patient to be accompanied by an interpreter at the time of appointment if they do not read/speak English.

PATIENT MEDICAL HISTORY

Is patient on anticoagulants, ASA, NSAIDS or natural blood thinners?
☐ No ☐ Yes
If yes, list: _____
_____

Allergies:
☐ No known drug allergies
☐ Latex
☐ Penicillin
☐ Other: _____

☐ Acute medical condition requiring hospitalization in past year: _____

☐ Cardiac Disorders
☐ Ischemic Heart Disease
☐ Hypertension
☐ Valvular Heart Disease
☐ Pacemaker/Internal Defibrillator
☐ Respiratory Disorders
☐ Asthma
☐ Chronic Obstructive Pulmonary Disease
☐ Kidney Disease
☐ Renal Insufficiency
☐ Abdominal Surgery
☐ Gynecological Surgery
☐ History of Gastrointestinal Bleeding
☐ History Colorectal Cancer

☐ Coagulation Disorders
☐ Hemophilia
☐ Diabetes
☐ Communicable Diseases
☐ HIV
☐ Hepatitis C
☐ Tuberculosis
☐ Other: _____

List any contact precautions (ie MRSA, VRE): _____

List current medications/ supplements and other relevant history:

PHYSICIAN INFORMATION

After discussion with you, the patient is willing to go for direct referral colonoscopy. Date: _____

Name:		
Address:	Signature:	
ENDOSCOPY USE ONLY	Phone:	Fax:
Date Received:		
Colonoscopist:	Initial Patient Contact Date:	Procedure Date/Time:
	Registered Nurse Consult Date/Time:	

TREFENDOCOLON