Thunder Bay Regional Health Sciences Centre

Endoscopy Services

COLONOSCOPY REFERRAL

Place Patient Label with Barcode Here

Guidelines:

1. Physician to complete referral.
2. Fax to Diagnostic Assessment Program at **807-684-5810.** Patient will be contacted by a qualified health care professional to organize the Colonoscopy booking.
3. Completed referral forms will be filed on the patient's health record

INDICATION FOR COLONOSCOPY

Screening	☐ PF - Patient (50-74yrs) referred after a positive Fecal Occult Blood Test Date: _____	☐ FD – Patient (74yrs old or younger) referred first-degree relative had colorectal cancer Specify relative: _____ Last Colonoscopy Date: _____
Symptomatic	☐ SA- Patient is symptomatic or has had an abnormal lab (other than Fecal Occult Blood Test)	☐ Rectal Bleeding ☐ Persistent Change in Bowel Habits ☐ Anemia ☐ Weight Loss ☐ New Onset Abdominal Pain ☐ Other Comments:
Surveillance	☐ CN- Surveillance for Colorectal Neoplasm or Disease	☐ Please attach most recent colonoscopy report and pathology report (if applicable). Comments:

*** Urgent Referrals (palpable rectal mass or abdominal imaging suspicious for colorectal cancer) should go directly to a colonoscopist ***

COLONOSCOPY REQUESTED

☐ First Available Screening Appointment OR Preferred Colonoscopist:

☐ Dr. S. Cassie ☐ Dr. E. Davenport ☐ Dr. K. Gehman ☐ Dr. W. Harris ☐ Dr. H. Telang
☐ Dr. P. Zezos ☐ Dr. M. Holmes ☐ Dr. A. Smith ☐ Dr. G. Mapeso ☐ Dr. M. Cooper ☐ Dr. K. Raman

PATIENT INFORMATION

Last Name, First Name: _____ Date of Birth (day/month/year) _____

Sex: ☐ Female ☐ Male Health Card Number: _____ Version Code: _____

Address _____ Telephone: Home _____

_____ Postal Code: _____ 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: _____

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

☐ 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 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:

Phone: Fax:

Signature:

ENDOSCOPY USE ONLY Date Received:

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