Central Colonoscopy Referral Program

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.
4. Questions - contact Diagnostic Assessment Program at 807-684- 6943

INDICATION FOR COLONOSCOPY

Screening (DAP)	☐ PF - Patient (50-74yrs) referred after a positive Fecal Occult Blood **Test Date**: ________________________ ☐ FT –Patient (50-74yrs) referred after a positive Fecal ImmunochemicalTest **Test Date**__________________	☐ FD – Patient (74yrs old or younger) referred first-degree relative had colorectal cancer **Specify relative**: ___________________________ **Relative age if known**_________________
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:____

PATIENT INFORMATION

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

Sex ☐ Female ☐ Male ☐ Unspecified 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: ______________________

Date of Last Colosonscopy___________________________________

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:		Signature:
Phone:	Fax:	