COLORECTAL SCREENING
COLONOSCOPY REFERRAL FORM

FAX TO: 613-354-8230

Instructions for Completion:

This referral form is ONLY to be used to refer a patient for colonoscopy with:

1. A confirmed abnormal Fecal Immunochemical Test (FIT) or Fecal Occult Blood Test (FOBT) (up until the phase out of this test); or

Primary Care Providers will be responsible for ensuring that patients with an abnormal FIT/FOBT result receive timely follow-up. ColonCancerCheck recommends follow-up with a colonoscopy within eight weeks of an abnormal FIT/FOBT result. Ensuring timely follow-up of an abnormal FIT result is particularly important due to the greater likelihood of abnormal findings associated with FIT-positive colonoscopies.

Please complete the form, attach any additional information you think may be relevant to your patient's health and fax all the information to:

Lennox & Addington County General Hospital
Facility Colon Screening Fax Number: 613-354-8230

Additional Information:

The following hospitals provide regional colonoscopy services for any patients who require a colonoscopy for an abnormal FIT/FOBT result. We may redirect your referral to any of the regional partner hospitals below to ensure that your patients receive timely access to a colonoscopy for an abnormal FIT/FOBT result.

Brockville General Hospital
Kingston Health Sciences Centre
Lennox & Addington County General Hospital
Perth Smith Falls District Hospital
Quinte Health Care

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Patient Label

Please advise patients: 1) The hospital will contact them with an appointment date/time 2) Bring their health card to the appointment

REFERRAL INFORMATION - Patient must be *asymptomatic* and meet the following criteria:

- Patient (50 years of age and older) referred after a positive Fecal Immunochemical Test (FIT) or Fecal Occult Blood Test (FOBT)

Indication for Referral:	Date of Positive FIT/FOBT:	Date of Referral:
Abnormal FIT	Patient Notified of Referral: Yes ☐ No	**Please Attach Test Results**

PATIENT INFORMATION (Please fill in below if patient label unavailable)

Last Name	First Name	Date of Birth:	
Address	City	Province	Postal Code
Home Phone	Mobile Phone	Work Phone	Preferred Contact Method

CURRENT MEDICAL HISTORY (Please include all pertinent lab and diagnostic information)

☐ No significant medical history

☐ **REQUIRED** Medical history attached

☐ Pacemaker/defibrillated
☐ Mechanical Valve
☐ Type 1 or 2 Diabetes: Please list medications below.
☐ Abnormal renal function:
Most recent serum creatinine level: _____ mcmol
Date:
Dialysis ☐ Yes ☐ No

Past 6 Months:
☐ MI
☐ Stroke
☐ DVT

Allergies: Yes ☐ No ☐ If yes, please list:

Medication Allergies: Yes ☐ No ☐ If yes, please list:

Other Concerns:

Mobility Issues: Yes ☐ No ☐ If yes, please describe: _____

Interpreter Needed: Yes ☐ No ☐ If yes, provide details: _____

Care provider or attendant required: Yes ☐ No ☐

Further information: _____

CURRENT MEDICATIONS (Please attach current medication list)

☐ No medications
☐ Oral hypoglycemic
☐ Insulin (specify):
_____
☐ NSAIDs (specify):
_____

Coumadin/Warfarin ☐ Yes ☐ No
Can be held for 5 days before procedure? ☐ Yes ☐ No

Plavix, Brilinta, or other systemic antiplatelet Rx ☐ Yes ☐ No
Can be held for 7 days before procedure? ☐ Yes ☐ No

Direct Oral Anticoagulant ☐ Yes ☐ No
(Dabigatran, Rivaroxaban, Apixaban, etc.)
Can be held for 2 days before procedure? ☐ Yes ☐ No

REFERRING CARE PROVIDER INFORMATION (Please fill if not stamped)

Address	City	Province	Postal code
Fax	Phone	Extension	
Name	Signature	OHIP#	CPSO #

HOSPITAL USE ONLY: ☐ Clinic Appointment Required ☐ Direct to Colonoscopy

Care Provider Stamp (If applicable):