



## **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

**COLORECTAL SCREENING - COLONOSCOPY REFERRAL FORM****FAX TO: # 613-354-8230****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)

<b>Indication for Referral:</b>	Date of Positive FIT/FOBT:	Date of Referral:
	Patient Notified of Referral: Yes <input type="checkbox"/> No <input type="checkbox"/>	<b>Please Attach Test Results</b>

**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)

<input type="checkbox"/> No significant medical history	<input type="checkbox"/> <b>REQUIRED</b> Medical history attached
<input type="checkbox"/> Pacemaker/defibrillated <input type="checkbox"/> Mechanical Valve <input type="checkbox"/> Type 1 or 2 Diabetes: Please list medications below. <input type="checkbox"/> Abnormal renal function: Most recent serum creatinine level: _____ mcmol Date: _____ Dialysis <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Past 6 Months:</b> <input type="checkbox"/> MI <input type="checkbox"/> Stroke <input type="checkbox"/> 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)

<input type="checkbox"/> No medications <input type="checkbox"/> Oral hypoglycemic <input type="checkbox"/> Insulin (specify): _____ <input type="checkbox"/> NSAIDs (specify): _____	<u>Coumadin/Warfarin</u>	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Can be held for 5 days before procedure?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<u>Plavix, Brilinta, or other systemic antiplatelet Rx</u>	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Can be held for 7 days before procedure?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<u>Direct Oral Anticoagulant</u> (Dabigatran, Rivaroxaban, Apixaban, etc.)	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Can be held for 2 days before procedure?	<input type="checkbox"/> Yes <input type="checkbox"/> 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):**