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).

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
Healthcard Number:
Patient Demographic:

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:
	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	Healthcard #

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

☐ No significant medical history	☐ **REQUIRED** Medical history attached
☐ Pacemaker/defibrillator ☐ 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/PE

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 Can be held for 5 days before procedure?	☐ Yes ☐ No ☐ Yes ☐ No
	Plavix, Brilinta, or other systemic antiplatelet Rx Can be held for 7 days before procedure?	☐ Yes ☐ No ☐ Yes ☐ No
	Direct Oral Anticoagulant (Dabigatran, Rivaroxaban, Apixaban, etc.) Can be held for 2 days before procedure?	☐ Yes ☐ No ☐ 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):

Comments: