

# FIT + COLONOSCOPY REFERRAL

Please fax to hospital of choice:

<input type="checkbox"/> Humber River 416-242-1075	<input type="checkbox"/> Mackenzie Health 905-883-2062	<input type="checkbox"/> Markham Stouffville 905-472-7386	<input type="checkbox"/> North York General 416-756-6926	<input type="checkbox"/> Southlake 905-954-3883	<input type="checkbox"/> Stevenson Memorial fax to specialist
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**Note: This referral form must only be used for FIT Positive (+) colonoscopy, and not any other indication.**

Send referral form within 1 (one) week of FIT Positive (+) result. \*Important - Attach lab result indicating positive FIT

<b>PATIENT NAME</b> (Print first, last)		<b>DOB</b> DD / MM / YYYY	
<b>HEALTH CARD NUMBER</b>	<b>VERSION CODE</b>	<b>SEX</b> <input type="checkbox"/> Male <input type="checkbox"/> Female	
<b>STREET ADDRESS</b>	<b>CITY/TOWN</b>	<b>PROVINCE</b>	<b>POSTAL CODE</b>
<b>PATIENT PREFERRED TELEPHONE NUMBER</b>			
<b>ALTERNATE NUMBER</b>			

**Medical History** Attach Complete Patient Profile (CPP), and previous colonoscopy reports where available.

<p><b>Medical Conditions</b></p> <p>Coagulation disorder <input type="checkbox"/> Yes <input type="checkbox"/> No _____</p> <p>Pacemaker/Internal Defibrillator <input type="checkbox"/> Yes <input type="checkbox"/> No _____</p> <p>Creatinine <math>\geq</math> 100) <input type="checkbox"/> Yes <input type="checkbox"/> No _____</p> <p>Arrhythmia <input type="checkbox"/> Yes <input type="checkbox"/> No _____</p> <p>Sleep Apnea <input type="checkbox"/> Yes <input type="checkbox"/> No _____</p> <p>Cognitive Impairment <input type="checkbox"/> Yes <input type="checkbox"/> No _____</p> <p>Respiratory disease <input type="checkbox"/> Yes <input type="checkbox"/> No _____</p> <p>Cirrhosis <input type="checkbox"/> Yes <input type="checkbox"/> No _____</p> <p>Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No _____</p> <p>Congestive Heart Failure <input type="checkbox"/> Yes <input type="checkbox"/> No _____</p> <p>Prosthetic Heart Valve/_ <input type="checkbox"/> Yes <input type="checkbox"/> No _____</p> <p>Endocarditis/CHF <input type="checkbox"/> Yes <input type="checkbox"/> No _____</p>	<p><b>Medications</b> (Attach current medication list if available)</p> <p><input type="checkbox"/> ASA <input type="checkbox"/> Iron</p> <p><input type="checkbox"/> Anticoagulant Eg. Warfarin, Dabigatran, Apixaban</p> <p><input type="checkbox"/> Antiplatelet Eg. Clopidogrel, Dipyridamole/Aspirin</p> <p><input type="checkbox"/> Other: _____</p> <p><input type="checkbox"/> Allergies (list below if any): <input type="checkbox"/> No Known Allergies</p> <p>_____</p> <p><input type="checkbox"/> Latex</p> <p>_____</p> <p>Prior Colonoscopy: <input type="checkbox"/> No <input type="checkbox"/> Yes DD / MM / YYYY</p>
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**Additional Relevant History:** \_\_\_\_\_

**BY SIGNING THIS FORM, I CONFIRM THAT THIS PATIENT IS AWARE OF THIS REFERRAL**

<b>Referring Physician Name:</b>	<b>Billing #:</b>		
<b>Referring Physician Address:</b>	<b>City/Town</b>	<b>Province</b>	<b>Postal Code</b>
<b>Referring Physician Signature:</b>	<b>Date:</b> DD / MM / YYYY		
<b>Phone Number:</b>	<b>Fax Number:</b>		