

## FIT + COLONOSCOPY REFERRAL

Please fax to hospital of choice:

<input type="checkbox"/> Humber River	<input type="checkbox"/> Mackenzie Health	<input type="checkbox"/> Markham Stouffville	<input type="checkbox"/> North York General	<input type="checkbox"/> Southlake	<input type="checkbox"/> Stevenson Memorial
<b>416-242-1075</b>	<b>905-883-2062</b>	<b>905-472-7386</b>	<b>416-756-6926</b>	<b>905-954-3884</b>	<b>fax to specialist</b>

**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> <i>(Print first, last)</i>		<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 _____</p> <p>Defibrillator            <input type="checkbox"/> Yes <input type="checkbox"/> No _____</p> <p>Creatinine ≥ 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/_ _____</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 Provider Name:</b>	<b>Billing #:</b>		
<b>Referring Provider Address:</b>	<b>City/Town</b>	<b>Province</b>	<b>Postal Code</b>
<b>Referring Provider Signature:</b>	<b>Date:</b> DD / MM / YYYY		
<b>Phone Number:</b>	<b>Fax Number:</b>		

# ColonCancerCheck: Central Region FIT + Colonoscopy Referral Form

## Facilities Performing FIT + Colonoscopies:

Alliston



### Humber River Hospital

1235 Wilson Ave, Toronto, ON M3M 0B2

ENDOSCOPY CLINIC

TEL: 416-242-1000 ext. 21600

FAX: **416-242-1075**

### Mackenzie Health

10 Trench St, Richmond Hill, ON L4C 4Z3

C5 AQUA PROCEDURES

TEL: 905-883-1212 ext. 7825

FAX: **905-883-2062**

### Markham Stouffville Hospital

381 Church St, Markham, ON L3P 7P3

SCHEDULING

TEL: 905-472-7654

FAX: **905-472-7386**

### North York General Hospital

4001 Leslie St, North York, ON M2K 1E1

ENDOSCOPY CLINIC

TEL: 416-756-6925

FAX: **416-756-6926**

### Southlake Regional Health Centre

581 Davis Dr, Newmarket, ON L3Y 2P9

DIAGNOSTIC ASSESSMENT UNIT

TEL: 905-895-4521 ext. 2969

FAX: **905-954-3884**

### Stevenson Memorial Hospital

200 Fletcher Cres, Alliston, ON L9R 1W7

**\*please fax this form directly to specialist**

PERIOPERATIVE PROGRAM

TEL: 705-435-6281 ext. 2233

Newmarket

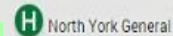


Markham

Vaughan



North York



Scarborough

