Central Regional Cancer Program
in partnership with Cancer Care Ontario

FIT + COLONOSCOPY REFERRAL

Please fax to hospital of choice:

☐ Humber River	☐ Mackenzie Health	☐ Markham Stouffville	☐ North York General	☐ Southlake	☐ Stevenson Memorial
416-242-1075	905-883-2062	905-472-7386	416-756-6926	905-954-3883	fax to specialist

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*

PATIENT NAME *(Print first, last)*		**DOB** DD / MM / YYYY	
HEALTH CARD NUMBER	**VERSION CODE**	**SEX** ☐ Male ☐ Female	
STREET ADDRESS	**CITY/TOWN**	**PROVINCE**	**POSTAL CODE**
PATIENT PREFERRED TELEPHONE NUMBER **ALTERNATE NUMBER**			

Medical History

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

Medical Conditions

Coagulation disorder	☐ Yes ☐ No	_____
Pacemaker/Internal Defibrillator	☐ Yes ☐ No	_____
Creatinine ≥ 100)	☐ Yes ☐ No	_____
Arrhythmia	☐ Yes ☐ No	_____
Sleep Apnea	☐ Yes ☐ No	_____
Cognitive Impairment	☐ Yes ☐ No	_____
Respiratory disease	☐ Yes ☐ No	_____
Cirrhosis	☐ Yes ☐ No	_____
Diabetes	☐ Yes ☐ No	_____
Congestive Heart Failure	☐ Yes ☐ No	_____
Prosthetic Heart Valve/_ Endocarditis/CHF	☐ Yes ☐ No	_____

Medications (Attach current medication list if available)

☐ **ASA** ☐ **Iron**

☐ **Anticoagulant** Eg. Warfarin, Dabigatran, Apixaban

☐ **Antiplatelet** Eg. Clopidogrel, Dipyridamole/Aspirin

☐ **Other:** _____

☐ Allergies (list below if any): ☐ No Known Allergies

_____

☐ Latex

_____

Prior Colonoscopy: ☐ No ☐ Yes DD / MM / YYYY

Additional Relevant History: _____

_____

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

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