Quinte Health

ABNORMAL FECAL IMMUNOCHEMICAL TEST (FIT)/ FECAL OCCULT BLOOD TEST (FOBT) COLONOSCOPY REFERRAL
FAX TO: # 613-961-2523

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)

Indication for Referral: ☐ Abnormal FIT ☐ Abnormal FOBT	Date of Positive FIT/FOBT:	Date of Referral:
	Patient Notified of Referral: Yes ☐ No ☐	If Yes, Date Notified:

PATIENT INFORMATION

Last Name	First Name	Date of Birth:	
Address	City	Province	Postal Code
Home Phone	Mobile Phone	Work Phone	Preferred Contact Method

CURRENT HEALTH STATUS

Is the patient experiencing any symptoms? Yes ☐ No ☐ Please describe any symptoms:

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

☐ No significant medical history ☐ Medical history attached

☐ Congestive Heart Failure ☐ Post MI ☐ Pacemaker/defibrillated ☐ Atrial fibrillation ☐ Mechanical valve ☐ Cirrhosis ☐ Post stroke	☐ Emphysema ☐ COPD ☐ Sleep Apnea ☐ Dementia ☐ Renal insufficiency ☐ Dialysis	☐ Type 1 Diabetes ☐ Type 2 Diabetes ☐ Uncontrolled hypertension Most recent blood pressure: _____ Date: (YYYY/MM/DD) ☐ Abnormal renal function: Most recent serum creatinine level: ____mcmol Date:(YYYY/MM/DD)

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

☐ No medications ☐ Oral hypoglycemic ☐ Insulin (specify): _____ ☐ Anticoagulant (specify): _____ ☐ NSAIDs / Platelet Inhibitor medications (specify)_____	☐ Other Medications (list): ☐ Medication list attached

PATIENT EDUCATION

☐ Additional information is included with this referral (where applicable) _____ Pages

REFERRING CARE PROVIDER INFORMATION

Address	City	Province	Postal code
Fax	Phone	Extension	
Name	Signature		CPSO #

HOSPITAL USE ONLY: ☐ Clinic Appointment Required ☐ Direct to Colonoscopy

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ABNORMAL FIT/FOBT COLONOSCOPY REFERRAL FORM

Instructions for Completion

This referral form is ONLY to be used to refer a patient for colonoscopy with 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:

Quinte Health
Fax: 613-961-2523

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 and Addington Country District Hospital
Perth Smith Falls District Hospital
Quinte Health