Colorectal Cancer Screening Program Referral Form

OR Booking Fax (613) 961-2523

First Name: Last Name: Gender: ☐ Male ☐ Female

Address: Date of Birth: ____ / ____ / ____ (YYYY / MM / DD)

Health Card Version: Home Phone:

Work Phone:

Mobile Phone:

Is the patient capable of giving their own informed consent ☐ **YES** ☐ **NO**

*Please note that if your patient does not read/speak English, he/she should be accompanied by an interpreter at the time of the appointment.

Indication–Patient must be asymptomatic and meet one of the following:

☐ **PF** Patient was referred after a Positive FOBT

☐ **FD** Patient was referred because a first-degree relative had Colorectal Cancer

Past Medical History

☐ Abnormal Renal Function
Most recent serum creatinine level: _____

☐ Anticoagulation/Coagulation Disorder
Indication: _____

☐ Prosthetic Heart Valve

☐ Emphsysema/Other Severe Pulmonary Disease

☐ Heart Disease

☐ Patient using Prophylactic Antibiotics

☐ Diabetes Mellitus on Medication *Oral* ___ *Insulin* ___

☐ History of Adverse Reaction to Sedation or Anaesthesia

Medications:

Other Past Medical History:

Allergies:

Provider Information

Referring Physician/ Nurse Practitioner: Phone:

Fax:

Signature:

Physician Billing #:

Colonscopy & Consultation Requested

Date of Referral:

☐ Referring To:

☐ Next Available appointment