

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 905-954-3884	<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*

PATIENT NAME <i>(Print first, last)</i>		DOB DD / MM / YYYY	
HEALTH CARD NUMBER	VERSION CODE	SEX <input type="checkbox"/> Male <input type="checkbox"/> 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.*

<p>Medical Conditions</p> <p>Coagulation disorder <input type="checkbox"/> Yes <input type="checkbox"/> No _____</p> <p>Pacemaker/Internal <input type="checkbox"/> Yes <input type="checkbox"/> No _____</p> <p>Defibrillator <input type="checkbox"/> Yes <input type="checkbox"/> No _____</p> <p>Creatinine \geq 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>Medications (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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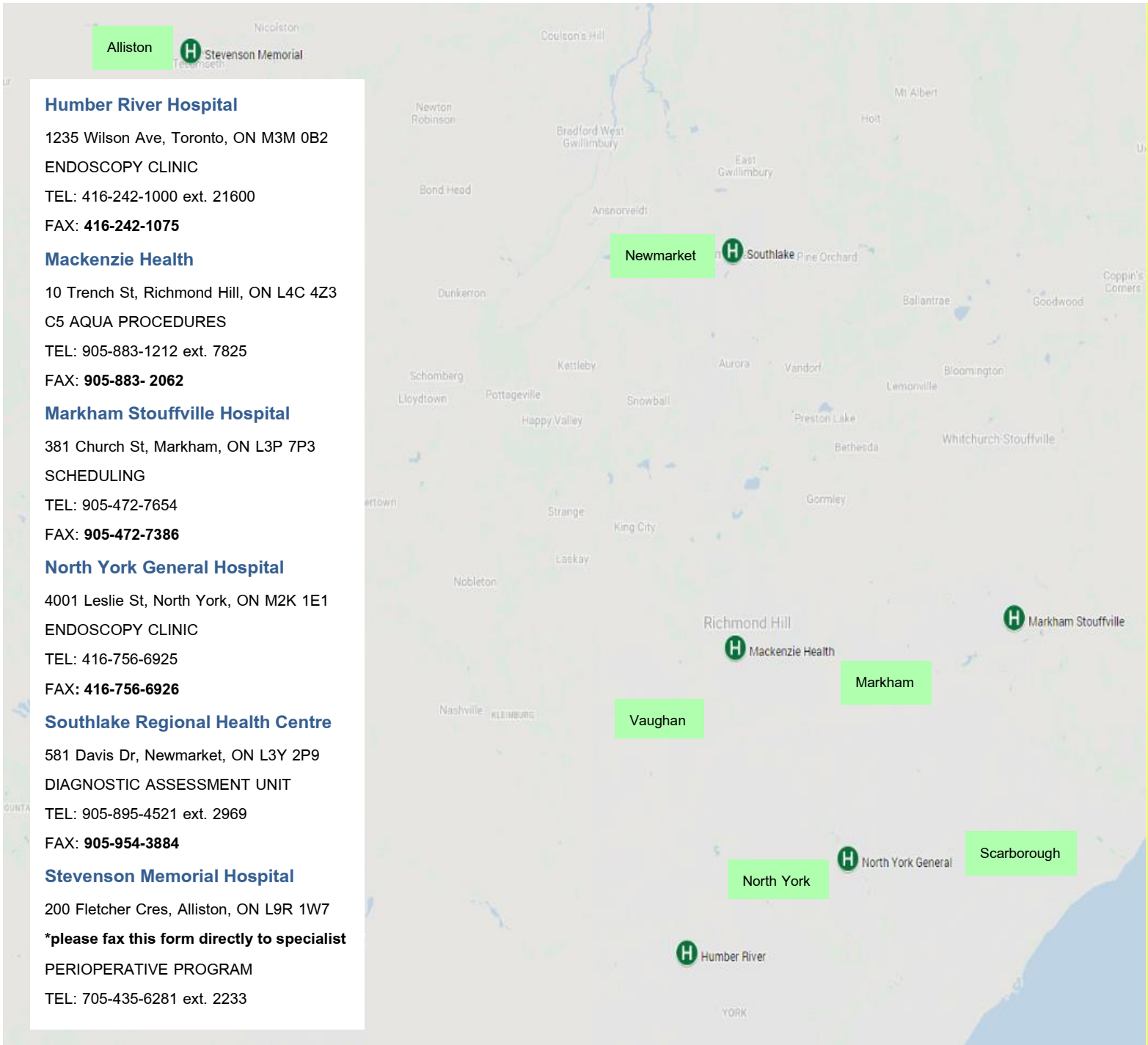
Additional Relevant History: _____

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

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

ColonCancerCheck: Central Region FIT + Colonoscopy Referral Form

Facilities Performing FIT + Colonoscopies:



The map displays the following facilities with their names highlighted in green boxes:

- Alliston
- Newmarket
- Vaughan
- North York
- Markham
- Scarborough

Other hospitals marked on the map include: Stevenson Memorial, Southlake, Richmond Hill, Mackenzie Health, North York General, and Humber River.

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