Fecal Immunochemical Test (FIT) Requisition – For Colorectal Cancer Screening

Form Completion Fee Code Q150

LifeLabs®

Eligibility Criteria:

- Age 50 to 74
- Asymptomatic
- No personal history of colorectal cancer, Crohn's disease involving the colon or ulcerative colitis
- No first-degree relative diagnosed with colorectal cancer
- No colorectal polyps needing surveillance
- Due for screening (no FIT in the last two years, and no flexible sigmoidoscopy or colonoscopy in the last 10 years)
- Valid Ontario Health Insurance Plan (OHIP) number

Lab Use Only

Note:
- Do not use for the workup of patients with overt GI bleeding and/or anemia.
- ColonCancerCheck does not recommend routine screening for people over 74 years. Decisions to screen those between the ages of 75 to 85 years should include an assessment of risks and benefits, and take into consideration health, life expectancy, and prior screening history. It is not appropriate to screen people over 85 years of age.

☐ Check box if patient requires a new FIT kit (i.e., FIT was lost, damaged, or not received) and complete this form. Call LifeLabs for questions: **1-833-676-1426**

All sections on this form must be accurate and complete. Fax the requisition to 1-833-676-1427

1. Requester Information

Requester Type (check one): ☐ Physician ☐ Nurse Practitioner ☐ Mobile Coach ☐ Telehealth Ontario	Mobile Coach ID:	CPSO or CNO Number:	OHIP Billing Number:
Last Name:	Middle Name (optional):	First Name:	
Office Address:		Office Phone Number:	
City:	Province:	Postal Code:	Fax Number:

Copy to: Physician/Nurse in Charge for Nursing Stations. If the same as Requester Information, do not complete this section.

Last Name:	Middle Name (optional):	First Name:	
Office Address:		Office Phone Number:	
City:	Province:	Postal Code:	Fax Number:

2. Patient Information (Cancer Care Ontario patient result letters and other correspondence will be sent to the Patient Address)

Last Name (on OHIP card):	Middle Name (on OHIP card, optional):	First Name (on OHIP card):	
Date of Birth (on OHIP card): yyyy/mm/dd	OHIP Number:	OHIP Version:	Sex: ☐ Male ☐ Female
Patient Address:		Primary Phone Number:	Ext. (optional)
City:	Province:	Postal Code:	Cell Phone Number (optional, if not primary number):	Type: ☐ Work ☐ Home ☐ Cell

3. FIT Kit Mailing Address (for patients who prefer to have their kit mailed to a different address within Ontario)

FIT Kit Mailing Address:

Facility Name (if applicable):			Primary Phone Number:	Type: ☐ Work ☐ Home ☐ Cell
City:	Province: Ontario	Postal Code:	Ext. (optional)	

4. Requester Verification

Requester Signature:	Date: yyyy/mm/dd

Ontario

Need this information in an accessible format? 1-855-460-2647, TTY 416-217-1815 publicaffairs@cancercare.on.ca