Health Sciences North
Horizon Santé-Nord

Colonoscopy Referral Form
Colorectal Cancer Diagnostic Assessment Program
Complete and FAX to 705-523-7303

An incomplete referral form will not be processed and will be returned to the referring provider.

PATIENT INFORMATION: Surname: _____ Given name: _____ DOB: _____
Address: (Apartment/Street) _____ City: _____
Province: _____ Postal code:_____
Telephone: Home:_____ Work:_____ Gender: ❒ Male ❒ Female
Health Card Number /Version Code: _____Patient aware of referral: ❒No ❒Yes

PATIENT MUST BE ASYMPTOMATIC AND MEET ONE OF THE FOLLOWING:
❒ Positive FOBT (Patient age 50+) (submit copy of lab result) **OR**
❒ First-degree relative had colorectal cancer Specify: ❒ Parent ❒ Sibling ❒ Child

COLONOSCOPIST: ❒ First Available **OR** ❒ Next Available Appointment with Dr._____
REFER ALL OTHER INDICATIONS FOR COLONOSCOPY DIRECTLY TO A SPECIALIST'S OFFICE

PATIENT MEDICAL HISTORY (To be completed by Referring Provider's Office)

❒ Latex Allergy Allergies (Please List):_____
Does the patient have any contact precautions? ❒ MRSA Other: _____
❒ MI ❒ Angina ❒ CHF ❒Atrial Fibrillation ❒ Cardiac Stent ❒ IHD
❒ Pacemaker/ICD (implanted cardiac defibrillator) ❒ CVA/TIA
❒ Mechanical valve, previous endocarditis, complex congenital heart disease
❒ Coagulation disorder/anticoagulation ❒Cirrhosis ❒GI Bleed ❒Diabetes ❒Insulin ❒Home Oxygen ❒Dialysis
❒ History of communicable disease i.e. Hepatitis C, HIV, TB
❒ History of anaesthetic problems (Malignant Hyperthermia)
❒ Other significant medical/surgical history. List: _____
❒ Previous colonoscopy; Year (if known) _____

MEDICATION DETAILS:
❒ ASA/NSAIDS/Cox 2 Inhibitor
❒ Anticoagulants
❒ Antiplatelet agents
❒ Diabetic medications (PO or subQ)

OTHER MEDICATIONS & SUPPLEMENTS: Please list or attach list
1)
2)
3)

SPECIAL NEEDS: Patient capable of giving his/her own Informed Consent ❒ No ❒ Yes
Deafness ❒ No ❒ Yes Language ❒ No ❒ Yes If yes, please specify need: _____
If your patient requires assistance in comprehending/communicating in English or French she/he should be accompanied by an assistant/interpreter at the time of appointment.
Physical needs ❒ No ❒ Yes If yes, please specify:_____

PHYSICIAN INFORMATION:
Referring physician: _____
Telephone: _____
Fax: _____
Date of referral: _____

Please use practice stamp where available

_____
Referring Physician Signature (mandatory)

Questions? Contact 705- 523-7100 extension 2509

Date received:	**Initial patient contact date:**	**Procedure date/time:**
Colonoscopist:	**RN consult date/time:**	