Endoscopy Services

SCREENING COLONOSCOPY REFERRAL

Guidelines:
1. Physician to complete referral.
2. **Fax to Endoscopy Services at 807-684-5859**. **Patient and Referring Physician will be contacted by Endoscopy with procedure date/time. Registered Nurse will also contact patient prior to procedure.**
3. Completed referral forms will be filed on the patient's health record.

Questions (?) – Contact Endoscopy 807-684-6184

INDICATION FOR SCREENING COLONOSCOPY ONLY

□ PF - Patient (50-74yrs) referred after a positive FOBT(Fecal Occult Blood Test)
Date: _____

□ FD – Patient (74yrs old or younger) referred first-degree relative had colorectal cancer
Specify relative: _____

ALL OTHER INDICATIONS FOR COLONOSCOPY NEED TO BE REFERRED DIRECTLY TO THE SPECIALIST'S OFFICE*

SCREENING COLONOSCOPY REQUESTED

□ First Available Screening Appointment **OR** Preferred Colonoscopist:

□ Dr. A. Alallam □ Dr. E. Davenport □ Dr. K. Gehman □ Dr. W. Harris
□ Dr. M. Holmes □ Dr. J. Joanes □ Dr. G. Mapeso
□ Dr. W. O'Hara □ Dr. K. Raman □ Dr. H. Telang

PATIENT INFORMATION

Last Name, First Name: _____ Date of Birth (day/month/year) _____

Sex: □ Female □ Male Health Card Number: _____ Version Code: _____

Address _____ Telephone: Home _____

_____ Work _____ Cell _____

Primary Contact (Last Name, First Name): _____

Relationship to Patient: _____ Phone Number: _____

□ Patient incapable of giving his/her own Informed Consent

Patient to be accompanied by an interpreter at the time of appointment if they do not read/speak English.

PATIENT MEDICAL HISTORY

Is patient on anticoagulants, ASA, NSAIDS or natural blood thinners?
□ No □ Yes
If yes, list: _____
_____

Allergies:
□ No known drug allergies
□ Latex
□ Penicillin
□ Other: _____

□ Acute medical condition requiring hospitalization in past year: _____

□ Cardiac Disorders
□ Ischemic Heart Disease
□ Hypertension
□ Valvular Heart Disease
□ Pacemaker/Internal Defibrillator
□ Respiratory Disorders
□ Asthma
□ Chronic Obstructive Pulmonary Disease
□ Kidney Disease
□ Renal Insufficiency
□ Abdominal Surgery
□ Gynecological Surgery
□ History of Gastrointestinal Bleeding
□ History Colorectal Cancer

□ Coagulation Disorders
□ Hemophilia
□ Diabetes
□ Communicable Diseases
□ HIV
□ Hepatitis C
□ Tuberculosis
□ Other: _____

List any contact precautions (ie MRSA, VRE): _____

List current medications/ supplements and other relevant history:

PHYSICIAN INFORMATION

After discussion with you, the patient is willing to go for direct referral colonoscopy. Date: _____

Name: _____ Signature: _____

Address: _____ Phone: _____ Fax: _____

ENDOSCOPY USE ONLY

Date Received:	Initial Patient Contact Date:	Procedure Date/Time:
Colonoscopist:	Registered Nurse Consult Date/Time:	