Kingston Health Sciences Centre
Centre des sciences de la santé de Kingston

Hôpital Hotel Dieu Hospital

KGH Hôpital Général de Kingston General Hospital

COLORECTAL SCREENING
COLONOSCOPY REFERRAL FORM

FAX TO: 613-544-5718

COLORECTAL SCREENING COLONOSCOPY REFERRAL FORM Instructions for Completion

This referral form is ONLY to be used to refer a patient for colonoscopy with:

1. A confirmed abnormal Fecal Immunochemical Test (FIT) or Fecal Occult Blood Test (FOBT) (up until the phase out of this test); or

2. First degree relative (parent, sibling, child) has colon cancer

Primary Care Providers will be responsible for ensuring that patients with an abnormal FIT/FOBT result receive timely follow-up. ColonCancerCheck recommends follow-up with a colonoscopy within eight weeks of an abnormal FIT/FOBT result. Ensuring timely follow-up of an abnormal FIT result is particularly important due to the greater likelihood of abnormal findings associated with FIT-positive colonoscopies.

Please complete the form, attach any additional information you think may be relevant to your patient's health and fax all the information to:

Hotel Dieu Hospital Site
Kingston Health Sciences Centre

Facility Colon Screening Fax number: 613-544-5718

Additional Information:

The following hospitals provide regional colonoscopy services for any patients who require a colonoscopy for an abnormal FIT/FOBT result. We may redirect your referral to any of the regional partner hospitals below to ensure that your patients receive timely access to a colonoscopy for an abnormal FIT/FOBT result.

Brockville General Hospital
Kingston Health Sciences Centre
Lennox and Addington Country District Hospital
Perth Smith Falls District Hospital
Quinte Health Care

Kingston Health Sciences Centre
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Patient Label

COLORECTAL SCREENING - COLONOSCOPY REFERRAL FORM
FAX TO: # 613-544-5718

Please advise patients: 1) The hospital will contact them with an appointment date/time 2) Bring their health card to the appointment

REFERRAL INFORMATION - Patient must be *asymptomatic* and meet the following criteria:

- Patient (50 years of age and older) referred after a positive Fecal Immunochemical Test (FIT) or Fecal Occult Blood Test (FOBT)
- Patient referred because one or more first degree relatives (parent, sibling, child) has colorectal cancer
  - *Note: age of referral recommended at age 50 years or ten years earlier than relative's diagnosis, whichever comes first*

Indication for Referral:	Date of Positive FIT/FOBT:	Date of Referral:
Abnormal FOBT	Patient Notified of Referral: Yes ☐ No ☐	If Yes, Date Notified:

PATIENT INFORMATION

Last Name	First Name	Date of Birth:	
Address	City	Province	Postal Code
Home Phone	Mobile Phone	Work Phone	Preferred Contact Method

CURRENT HEALTH STATUS

Is the patient experiencing any symptoms? Yes ☐ No ☐ Please describe any symptoms:

CURRENT MEDICAL HISTORY (please include all pertinent lab and diagnostic information)

☐ No significant medical history ☐ Medical history attached

☐ Congestive Heart Failure	☐ Emphysema	☐ Type 1 Diabetes
☐ Post MI	☐ COPD	☐ Type 2 Diabetes
☐ Pacemaker/defibrillated	☐ Sleep Apnea	☐ Uncontrolled hypertension
☐ Atrial fibrillation	☐ Dementia	Most recent blood pressure: _____
☐ Mechanical valve	☐ Renal insufficiency	Date:
☐ Cirrhosis	☐ Dialysis	☐ Abnormal renal function:
☐ Post stroke		Most recent serum creatinine level: ____ mcmol
		Date:

Allergies: Yes ☐ No ☐ If yes, please list:

Other Concerns:

Mobility Issues: Yes ☐ No ☐ If yes, please describe: _____

Interpreter Needed: Yes ☐ No ☐ If yes, provide details: _____

Care provider or attendant required: Yes ☐ No ☐

Further information: _____

CURRENT MEDICATIONS

☐ No medications	☐ Other Medications (list):
☐ Oral hypoglycemic	
☐ Insulin (specify): _____	
☐ Anticoagulant (specify): _____	☐ Medication list attached
☐ NSAIDs / Platelet Inhibitor medications (specify)_____	

PATIENT EDUCATION

☐ Additional information is included with this referral (where applicable) _____ Pages

REFERRING CARE PROVIDER INFORMATION

Address	City	Province	Postal code
Fax	Phone	Extension	
Name	Signature		CPSO #

HOSPITAL USE ONLY: ☐ Clinic Appointment Required ☐ Direct to Colonoscopy