Colorectal Cancer Screening Program Referral Form

OR Booking Fax (613) 961-2523

First Name: ______ Last Name: ______ Gender: ☐ Male ☐ Female

Address: ______ Date of Birth: ____ / ____ / ____ (YYYY MM DD)

Health Card ______ Version: ______

Home Phone: ______

Work Phone: ______

Mobile Phone: ______

Is the patient capable of giving their own informed consent ☐ **YES** ☐ **NO**

*Please note that if your patient does not read/speak English, he/she should be accompanied by an interpreter at the time of the appointment.

Indication–Patient must be asymptomatic and meet one of the following:

☐ **PF** Patient was referred after a Positive FOBT

☐ **FD** Patient was referred because a first-degree relative had Colorectal Cancer

Past Medical History

☐ Abnormal Renal Function
Most recent serum creatinine level: ____________

☐ Anticoagulation/Coagulation Disorder
Indication: ______________________________

☐ Prosthetic Heart Valve

☐ Emphysema/Other Severe Pulmonary Disease

☐ Heart Disease

☐ Patient using Prophylactic Antibiotics

☐ Diabetes Mellitus on Medication *Oral* ___ *Insulin* ___

☐ History of Adverse Reaction to Sedation or Anaesthesia

Medications: ______

Other Past: Medical History ______

Allergies: ______

Provider Information

Referring Physician/ Nurse Practitioner: ______ Phone: ______

Fax: ______

Signature: ______

Physician Billing #: ______

Colonscopy & Consultation Requested

Date of Referral: ______

☐ Referring To ______

☐ Next Available appointment