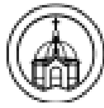


## COLORECTAL CANCER SCREENING REFERRAL

Telephone: 613-544-3400 Ext. 2453

www.hoteldieu.com

***Sponsored by Cancer Care Ontario***

PATIENT INFORMATION

Name ______________________________

DOB (YYYY/MM/DD) ______________________________

OHIP # ____________________ Version ________

CR # ______________________________

Phone # Home:______________________________

Work: ______________________________

Alternate: ______________________________

Address ______________________________

______________________________

### Indication for Referral - *Patient must be asymptomatic and meet one of the following*:

- ☐ Patient ( >*50 years of age*) referred after a Positive Fecal Occult Blood Test (FOBT) – ***please attach results***
- ☐ Patient referred because one or more first degree relative, *(parent, sibling, child),* had colorectal cancer

  ***Note:*** *Age of referral recommended at age 50 years or ten years earlier than relative's diagnosis, whichever comes first*

### Medical History - Check appropriate box(s)

Height: ____________m Weight: ____________ kg

Adverse Reactions: ☐ No ☐ Yes, If Yes list: ______________________________

- ☐ Anticoagulation/Coagulation disorder - *Specify:* ______________________________
- ☐ Patient using NSAIDS/Platelet Inhibitor medication - *Specify:* ______________________________
- ☐ Diabetes Mellitus on medication ☐ *Oral Hypoglycemic* ☐ *Insulin - Specify*______________________
- ☐ Emphysema/other severe Pulmonary Disease - *Specify:* ______________________________
- ☐ Pacemaker/Implantable Cardiac Defibrillator (ICD) - *Specify:* ______________________________
- ☐ Heart Disease: ☐ Valvular ☐ Coronary Artery
- ☐ Uncontrolled Hypertension - *Most recent blood pressure*________________ Date (YYYY/MM/DD) __________
- ☐ Abnormal Renal Function - *Most recent Serum Creatinine level:* ______ mcmol Date (YYYY/MM/DD) __________
- ☐ **No Comorbid condition(s)**

Medications (List): ______________________________

______________________________

Other______________________________

### Referring Physician Information

Printed Name: ______________________________

Telephone: ______________________________ Fax: ______________________________

Referring Physician Signature: ______________________ Date of Referral (YYYY/MM/DD) ____________

***Please inform patients that:***

1. They will be contacted by the Hospital with the appointment date and time.
2. Remind your patient to bring their health card.

## *FAX TO ENDOSCOPY UNIT - Fax # 613-544-5718*

**Hospital/Physician's Office Use Only**

☐ Clinic Appointment Required ☐ Direct to Colonoscopy