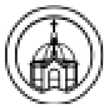

REGISTERED NURSE PERFORMED FLEXIBLE SIGMOIDOSCOPY REFERRAL FORM

Telephone: 613-544-3400 Ext. 2409

www.hoteldieu.com

Pilot Project 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 the following criteria*

- ☐ Patient age 50 to 74 years of age
- ☐ No history of inflammatory bowel disease
- ☐ No history of large bowel symptoms, e.g., rectal bleeding, sudden change in bowel habits, sudden constipation or diarrhea
- ☐ No new or significant change in bowel habits in the past six (6) months
- ☐ No first degree relative with history of colon cancer
- ☐ No previous colon cancer or rectal cancer
- ☐ No previous polyps

Medical History

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

☐ Anticoagulation/Coagulation disorder - *Specify:* ______________________________

☐ Heart Disease: ☐ Valvular ☐ Coronary Artery

☐ **No Comorbid condition(s)**

Other______________________________

Referring Physician Information

Printed Name: ______________________________

Telephone: ______________________ Fax: ______________________

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

Patient notified of referral: ☐ No ☐ Yes, If Yes indicate date (YYYY/MM/DD): ______________________

Please inform patients that:
They will be contacted by the Hospital with the appointment date and time.
They need to bring their health card.

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