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
Centre des sciences de la santé de Kingston

Hôpital Hotel Dieu Hospital

KGH Hôpital Général de Kingston General Hospital

**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 FIT | Patient Notified of Referral: Yes ☐ No ☐ If Yes, Date Notified: | |
| | Test Results Attached: Yes ☐ No ☐ | |

**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: Most recent serum creatinine level:_____mcmol |
| ☐ Post stroke | | 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
☐ Oral hypoglycemic
☐ Insulin (specify): _____
☐ Anticoagulant (specify): _____
☐ NSAIDs / Platelet Inhibitor medications (specify)_____

☐ Other Medications (list):

☐ Medication list attached

**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