



## REFERRAL FORM

### Colorectal Cancer Screening

Champlain Facilities offering screening related colonoscopies or Flexible Sigmoidoscopies are attached with fax and telephone numbers

#### PATIENT INFORMATION

First name		Last name		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Address		City		Postal Code
DOB (yyyy/mm/dd)	Main language(s) spoken	Ontario Health card #		
Phone (home)	(work)	(cell)		
Email:				

#### INDICATION FOR REFERRAL Please select one procedure and check appropriate box(es) in section below

**This referral form is not to be used for symptomatic patients**

- ☐ **Colonoscopy**  
☐ FIT Positive    ☐ FOBT    ☐ First degree relative; no prior colonoscopy
- ☐ **RN flexible sigmoidoscopy (RNFS): patient must meet all criteria**    **Note:** RNFS is only available at TOH; MD FS can be performed anywhere
- ☐ Man or woman age 50 to 74
- ☐ Average risk of colorectal cancer
- No first degree relative (parent, sibling, child) who has been diagnosed with colorectal cancer
  - No personal history of previous polyps (with the exception of rectal hyperplastic polyps) or colorectal cancer
  - No personal history of inflammatory bowel disease (i.e. Crohn's disease or ulcerative colitis)
- ☐ Asymptomatic
- ☐ Due for colorectal cancer screening (No FOBT/FIT in the past two years; No flexible sigmoidoscopy or colonoscopy in the past 10 years)

#### REFERRING PHYSICIAN

Significant Medical History:  
(Include Significant history of lung, kidney or heart disease)

Allergies:

Medication(s):

Renal Failure: <input type="checkbox"/> Yes <input type="checkbox"/> No	Sleep apnea: <input type="checkbox"/> Yes <input type="checkbox"/> No	Antiplatelet agent <input type="checkbox"/> Yes <input type="checkbox"/> No
Congestive Heart failure: <input type="checkbox"/> Yes <input type="checkbox"/> No	Anticoagulation agents: <input type="checkbox"/> Yes <input type="checkbox"/> No	Implantable defibrillator in place <input type="checkbox"/> Yes <input type="checkbox"/> No

Referring physician or Nurse Practitioner name (print)	Signature	Date (yyyy/mm/dd)
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CPSO #:

Phone	Fax
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#### HOSPITAL USE ONLY

Date referral received (yyyy/mm/dd):	Eligibility checked: <input type="checkbox"/> FOBT <input type="checkbox"/> RNFS <input type="checkbox"/> FIT
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FIT READY FACILITIES	
Facility	Fax
Arnprior Regional Hospital	613-623-3354
Cornwall Community Hospital	613-938-5539
Hawkesbury & District General Hospital Inc.	613-636-6221
Montfort	613-748-4968
Kemptville District Hospital	613-258-4997
Renfrew Victoria Hospital	613-432-5054
The Ottawa Hospital	613-761-4388
Pembroke Regional Hospital	613-732-2085 613-732-6347
Winchester District Memorial Hospital	613-774-6856
Queensway Carleton	613-721-5368