Version 1.0, May 2019

Hamilton Niagara Haldimand Brant Regional Cancer Program
in partnership with Cancer Care Ontario

Colonoscopy Referral Form

INDICATION:

☐ FIT+ ☐ 1st Degree Family History

Referral Date: _____
YYYY/MM/DD

Patient Last Name	First Name
HIN/HCN/OHCN/OHIP#	Date of Birth (yyyy/mm/dd) (Age)
Sex on Health Card ☐ M ☐ F ☐ X	Gender
Full Address	
Phone Number	Mobile Number
Family Physician	

I. SITE OF REFERRAL

Refer to:

☐ **Brantford General Hospital**
Phone: 519-751-5545
Fax: 519-752-9983

☐ **Haldimand War Memorial Hospital**
Phone: 905-774-7533
Fax: 905-774-7534

☐ **Hamilton Health Sciences**
Phone: 905-521-2100 x76933
Fax: 905-526-0594

☐ **Joseph Brant Hospital**
Phone: 905-632-3730 x5563
Fax: 905-681-4961

☐ **Niagara Health**
Phone: 905-378-4647 x44757
Fax: 905-688-8288

☐ **Norfolk General Hospital**
Phone: 519-426-0130 x2280
Fax: 519-429-6899

☐ **St. Joseph's Healthcare Hamilton**
Phone: 905-522-1155 x33289
Fax: 905-540-6514

☐ **West Haldimand General Hospital**
Phone: 905-768-3311 x1138
Fax: 905-768-8670

II. REFERRING PROVIDER

Name: Signature: OHIP Billing #:

Phone Number: Fax Number:

Address:

City: Province: Postal Code:

Your patient may be referred directly for a consultation and colonoscopy at the same visit. In order to ensure patient safety and suitability for this examination, the following must be completed.

III. PATIENT HISTORY

1. **Has patient had a prior colonoscopy?** ☐ Yes → (attach copy of most recent report(s) with this referral) ☐ No
2. **Does patient have a history of colon polyps?** ☐ Yes → (attach copy of most recent report(s) with this referral) ☐ No
3. **Does patient take any of the following agents?**
   - ☐ Anticoagulants → *identify medication(s) and indication:* _____
   - ☐ Antiplatelets → *identify medication(s) and indication:* _____
4. **Does patient have the following medical conditions?**

Coronary artery disease with unstable angina or a recent MI (within the past 12 months)?	☐ Yes	☐ No
Congestive heart failure?	☐ Yes	☐ No
Implanted cardiac pacemaker and/ or defibrillator (ICD)?	☐ Yes	☐ No
Diabetes on insulin?	☐ Yes	☐ No
Chronic renal failure (eGFR <60 ml/min)?	☐ Yes	☐ No
Significant respiratory disease (COPD, sleep apnea, restrictive lung disease)?	☐ Yes	☐ No
History of adverse reaction to sedation or anaesthesia?	☐ Yes	☐ No
Substance/ alcohol use disorder and/ or chronic high dose opioid or benzodiazepine utilization?	☐ Yes	☐ No

IV. REPORTS

The following reports have been faxed with this referral:
☐ FIT Results ☐ Current medication list ☐ Current allergy list ☐ Previous colonoscopy and pathology reports

**All referrals MUST be complete and submitted with relevant additional reports, as identified above.
Incomplete forms will not be processed.**