Central Regional Cancer Program
in partnership with Cancer Care Ontario

FIT + COLONOSCOPY REFERRAL

Please fax to hospital of choice:

☐ Humber River	☐ Mackenzie Health	☐ Markham Stouffville	☐ North York General	☐ Southlake	☐ Stevenson Memorial
416-242-1075	**905-883-2062**	**905-472-7386**	**416-756-6926**	**905-954-3883**	**fax to specialist**

Note: This referral form must only be used for FIT Positive (+) colonoscopy, and not any other indication.

Send referral form within 1 (one) week of FIT Positive (+) result. **Important - Attach lab result indicating positive FIT*

PATIENT NAME *(Print first, last)*		**DOB** DD / MM / YYYY	
HEALTH CARD NUMBER	**VERSION CODE**	**SEX** ☐ Male ☐ Female	
STREET ADDRESS	**CITY/TOWN**	**PROVINCE**	**POSTAL CODE**
PATIENT PREFERRED TELEPHONE NUMBER			
ALTERNATE NUMBER			

Medical History

Attach Complete Patient Profile (CPP), and previous colonoscopy reports where available.

Medical Conditions

Coagulation disorder	☐ **Yes** ☐ **No** _____
Pacemaker/Internal Defibrillator	☐ **Yes** ☐ **No** _____
Creatinine ≥ 100)	☐ **Yes** ☐ **No** _____
Arrhythmia	☐ **Yes** ☐ **No** _____
Sleep Apnea	☐ **Yes** ☐ **No** _____
Cognitive Impairment	☐ **Yes** ☐ **No** _____
Respiratory disease	☐ **Yes** ☐ **No** _____
Cirrhosis	☐ **Yes** ☐ **No** _____
Diabetes	☐ **Yes** ☐ **No** _____
Congestive Heart Failure	☐ **Yes** ☐ **No** _____
Prosthetic Heart Valve/_ Endocarditis/CHF	☐ **Yes** ☐ **No** _____

Medications (Attach current medication list if available)

☐ **ASA** ☐ **Iron**

☐ **Anticoagulant** Eg. Warfarin, Dabigatran, Apixaban

☐ **Antiplatelet** Eg. Clopidogrel, Dipyridamole/Aspirin

☐ **Other:** _____

☐ Allergies (list below if any): ☐ No Known Allergies

_____

☐ Latex

_____

Prior Colonoscopy: ☐ No ☐ Yes DD / MM / YYYY

Additional Relevant History: _____

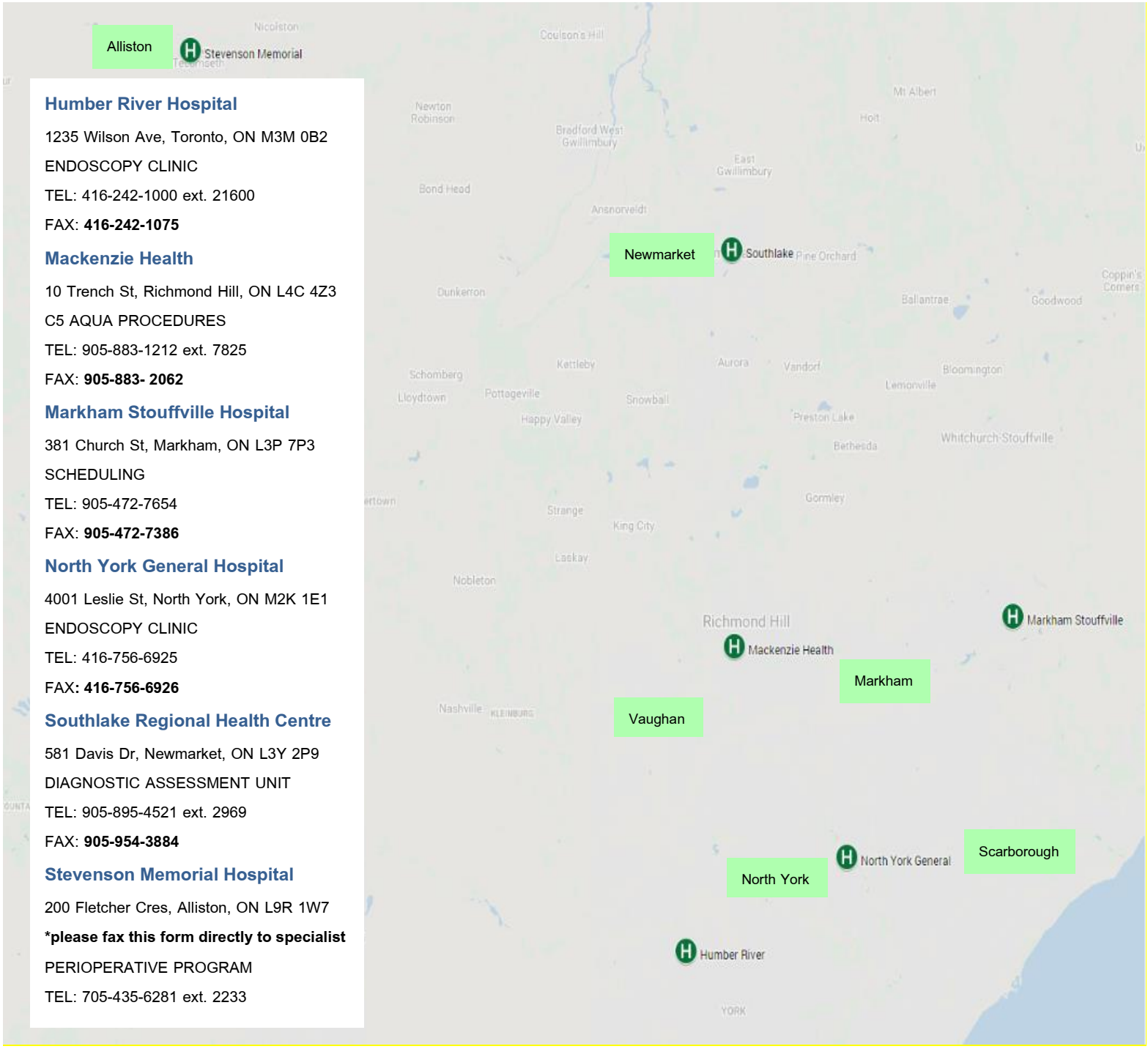
_____

BY SIGNING THIS FORM, I CONFIRM THAT THIS PATIENT IS AWARE OF THIS REFERRAL

Referring Physician Name:	**Billing #:**		
Referring Physician Address:	**City/Town**	**Province**	**Postal Code**
Referring Physician Signature:	**Date:** DD / MM / YYYY		
Phone Number:	**Fax Number:**		

ColonCancerCheck: Central Region FIT + Colonoscopy Referral Form

Facilities Performing FIT + Colonoscopies:



Humber River Hospital

1235 Wilson Ave, Toronto, ON M3M 0B2

ENDOSCOPY CLINIC

TEL: 416-242-1000 ext. 21600

FAX: **416-242-1075**

Mackenzie Health

10 Trench St, Richmond Hill, ON L4C 4Z3

C5 AQUA PROCEDURES

TEL: 905-883-1212 ext. 7825

FAX: **905-883- 2062**

Markham Stouffville Hospital

381 Church St, Markham, ON L3P 7P3

SCHEDULING

TEL: 905-472-7654

FAX: **905-472-7386**

North York General Hospital

4001 Leslie St, North York, ON M2K 1E1

ENDOSCOPY CLINIC

TEL: 416-756-6925

FAX**: 416-756-6926**

Southlake Regional Health Centre

581 Davis Dr, Newmarket, ON L3Y 2P9

DIAGNOSTIC ASSESSMENT UNIT

TEL: 905-895-4521 ext. 2969

FAX: **905-954-3884**

Stevenson Memorial Hospital

200 Fletcher Cres, Alliston, ON L9R 1W7

***please fax this form directly to specialist**

PERIOPERATIVE PROGRAM

TEL: 705-435-6281 ext. 2233