COLONCANCERCHECK PROGRAM REFERRAL FORM

To submit referral to The Ottawa Hospital, please fax this form to:	613-761-4388
To submit referral to Montfort Hospital, please fax this form to:	613-748-4968
To submit referral to Queensway Carleton Hospital, please fax this form to:	613-721-5368

First Name: **Last Name:**	**Gender: Male:** ☐ **Female:** ☐
Address:	**DOB (max 74 years):**
Address 2:	**Home phone:**
Family physician:	**Work phone:**
Health card #: **Version:**	**Mobile phone:**

Is the patient capable of giving their own informed consent? **Yes:** ☐ **No:** ☐

Main language spoken:

If the patient does not read/speak English or French, he/she should be accompanied by an interpreter at the time of the appointment.

Indication for referral:

Only applicable for patients 50 to 74 years who

1. PF: have a positive Fecal Occult Blood Test (FOBT) Yes: ☐ No: ☐
2. FD: have a first-degree relative (parent, sibling, child) who has been diagnosed with colorectal cancer. Yes: ☐ No: ☐

May start 10 years younger than the age at which relative was diagnosed.

If both indicators are "no", please DO NOT SEND REFERRAL TO THE COLONCANCERCHECK PROGRAM. Please continue to use your existing specialist referral channels for patients presenting with symptoms requiring investigation OR patients requiring colonoscopy for other reasons.

SIGNIFICANT MEDICAL HISTORY (Please complete entire section)

Renal Failure	Yes: ☐	No: ☐	Respiratory Disease	Yes: ☐	No: ☐
Prosthetic Heart Valve	Yes: ☐	No: ☐	Diabetes Mellitus on medication	Yes: ☐	No: ☐
Anticoagulation/coagulation disorder	Yes: ☐	No: ☐	Heart Disease	Yes: ☐	No: ☐
Sleep Apnea	Yes: ☐	No: ☐	Other medical conditions	Yes: ☐	No: ☐

Medication:	Significant Past Medical History:
Allergies:	Abnormalities:

FURTHER REFERRAL:

If any suspicious abnormality is found at endoscopy requiring further treatment by a surgeon, do you authorize referral to another physician/facility for appropriate treatment?

Yes: ☐ Montfort Hospital: ☐ Queensway Carleton Hospital: ☐ The Ottawa Hospital: ☐

No, I will arrange this myself: ☐

Referring doctor:	Phone:
CPSO #:	
Signature:	Fax:

Colonoscopy Screening Appointment Date (HOSPITAL USE ONLY):

Suspicious Abnormality found (HOSPITAL USE ONLY): **Yes:** ☐ **No:** ☐