



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 <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> X	Gender
Full Address	
Phone Number	Mobile Number
Family Physician	

I. SITE OF REFERRAL

Refer	<input type="checkbox"/> Brantford General Hospital Phone: 519-751-5545 Fax: 519-752-9983	<input type="checkbox"/> Haldimand War Memorial Hospital Phone: 905-774-7533 Fax: 905-774-7534	<input type="checkbox"/> Hamilton Health Sciences Phone: 905-521-2100 x76933 Fax: 905-526-0594	<input type="checkbox"/> Joseph Brant Hospital Phone: 905-632-3730 x5563 Fax: 905-681-4961
	<input type="checkbox"/> Niagara Health Phone: 905-378-4647 x44757 Fax: 905-688-8288	<input type="checkbox"/> Norfolk General Hospital Phone: 519-426-0130 x2280 Fax: 519-429-6899	<input type="checkbox"/> St. Joseph's Healthcare Hamilton Phone: 905-522-1155 x33289 Fax: 905-540-6514	<input type="checkbox"/> West Haldimand General Hospital Phone: 905-768-3311 x1138 Fax: 905-768-8670

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

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

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