

Patient Information (or affix sticker)

Name: _____	Address: _____
City: _____	Postal Code: _____
Home Phone: _____	Alt. Phone: _____
DOB (D/M/Y): _____	Gender: _____
HCN: _____	Family Physician: _____

REFERRING PROVIDER INFORMATION

Name: _____	Billing Number: _____
Phone: _____	Fax: _____
Date of Referral (D/M/Y): _____	Signature: _____

INDICATION FOR REFERRAL

Average Risk Screening	Gastroscopy
1st Degree Relative with Colon Cancer	Clinical indication for referral: _____
Personal History of Colon Adenoma(s)	Symptoms (e.g. rectal bleeding, change in bowel habits): _____

PATIENT HISTORY

- Has patient had a prior colonoscopy N Y (attach a copy of most recent reports with this referral)
- Does patient have a history of colon polyps N Y (attach a copy of most recent reports with this referral)
- Does patient take any of the following agents

ASA	Pradaxa (Dabigatran)	Plavix (Clopidogrel)	Xarelto (Rivaroxaban)
Coumadin (Warfarin)	Eloquis (Apixaban)	Brilinta (Ticagrelor)	
- Does patient have the following medical conditions

Coronary artery disease with unstable angina or a recent MI (within the past 12 months)?	Y	N
Congestive heart failure?	Y	N
Implanted cardiac pacemaker and/or defibrillator (ICD)?	Y	N
Diabetes on insulin?	Y	N
Chronic renal failure (eGFR <60 ml/min)?	Y	N
Significant respiratory disease (COPD, sleep apnea, restrictive lung disease)?	Y	N
History of adverse reaction to sedation or anaesthesia?	Y	N
Substance/alcohol use disorder and/or chronic high dose opioid or benzodiazepine utilization?	Y	N
Coagulopathy or platelets < 50?	Y	N

Thank you for the referral. JBH will contact your office to confirm receipt of referral and will contact your patient with relevant appointment dates and times.