hospital ORILLIA SOLDIERS' MEMORIAL

Colorectal Cancer Screening Program
Colonoscopy Referral Form
Phone: (705)-325-2201 Ext 3105
Fax: (705)-330-3228

1. Patient Information

First name: _____ **Last name:** _____ **Sex:** ☐ Male ☐ Female

D.O.B.: _____ / ____ / ____ (YYYY / MM / DD)

Address: _____

_____ **Phone(H):** _____-_____-_____

Health Card: _____ **Version:** _____ **Phone(W):** _____-_____-_____

☐ **Patient Incapable of Giving Her/His Own Informed Consent** **Phone(C):** _____-_____-_____

* Please note that if your patient does not read/speak English, he/she should be accompanied by an interpreter at the time of the appointment.

2. Indication - Patient must be asymptomatic and meet one of the following:

☐ **1. Patient was referred after a Positive FOBT (PF)**
☐ **2. Patient was referred because a first-degree relative had Colorectal Cancer (FD)**

3. Past Medical History

☐ Abnormal Renal Function
Most recent serum creatinine level: _____
☐ Diabetes Mellitus on Medication
☐ *Oral Hypoglycemics* ☐ *Insulin* _____
☐ Emphysema/Other Severe Pulmonary Disease
☐ Heart Disease

☐ Anticoagulation/Coagulation disorder
Indication: _____
☐ History of Adverse Reaction to Sedation or Anesthesia
☐ Patient using prophylactic Antibiotics
☐ Previous Abdominal / Pelvic Surgery
☐ Other: _____

Medications: ☐ None _____
_____
_____

Allergies: ☐ None _____
_____
_____

4. Provider Information

Referring Physician: _____ **Signature:** _____

Phone#: _____ **Fax#:** _____ **Physician Billing #:** _____

Date of Referral: _____

Colonoscopy & Consultation Requested:
☐ Next Available Appointment
☐ Dr: _____

5. Hospital Use Only

Colonoscopy / Consultation Appointment Date: _____ **Time:** _____

OUR RECEPTIONIST WILL CONTACT YOUR PATIENT RE: APPOINTMENT DATE AND TIME