North Bay Regional Health Centre

Surgery Care Centre

Colorectal Cancer Screening Clinic Referral Form

Patient's Last Name: _____
Patient's First Name: _____
Age: _____ Gender: ❑ Male ❑ Female
Home Phone: _____
Work Phone: _____
Other: _____
Health Card #: _____
Family Physician: _____

Reason for Referral

Patient must be ASYMPTOMATIC, ages 50-74 years (or ten years younger than the age at which a first degree relative was diagnosed with colorectal cancer, whichever is younger) and meet one of the following:

1. Positive **Fecal Occult Blood Test (FOBT)** ❑ Yes ❑ No
2. First degree relative (mother, father, child, or sibling) had colorectal cancer ❑ Yes ❑ No

(If both indicators are "no", please DO NOT SEND REFERRAL to the colorectal cancer screening program. Please continue to use your existing specialist referral channels for other screening or patients presenting symptoms requiring further investigation by a specialist).

PATIENT MEDICAL HISTORY (Please complete entire section)

MI (less than 6 months ago)	❑ Yes ❑ No	Renal Impairment on dialysis	❑ Yes ❑ No
Unstable angina/ CHF	❑ Yes ❑ No	Cirrhosis/Liver failure with complications	❑ Yes ❑ No
Pacemaker/ICD	❑ Yes ❑ No		
Anticoagulants	❑ Yes ❑ No	Severe Asthma / COPD	❑ Yes ❑ No
Coagulation disorder	❑ Yes ❑ No		

If "YES" answered to any of the above questions, DO NOT SEND REFERRAL to the colorectal cancer screening program, a direct referral to endoscopist is required.

Other Medical Conditions: _____
Medications: _____
Allergies: _____
Latex: ❑ Yes ❑ No
Family Physician's Signature: _____

FAX COMPLETED FORM TO (705) 495-2419

If you have any question you can contact the Ambulatory Care Clinic (ACU) at extension 3800

For Hospital Use Only

Date Referral received: _____
Colorectal screening appointment date: _____
Colonoscopy procedure date: _____ Arrival time: _____ Procedure time: _____