North Bay Regional Health Centre

Outpatient Endoscopy
Colorectal Cancer Screening Clinic Referral Form

To qualify for Colorectal Cancer Screening Clinic, the patient must not have had a previous scope, if so, the patient is to be referred to their previous Endoscopist

Reason for Referral

Patients 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
   Date of positive test from lab *day / month / year*
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	❑ Yes ❑ No
Pacemaker/ICD	❑ Yes ❑ No	complications	
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 Allergy: ❑ Yes ❑ No

Family Physician's Signature: _____

FAX COMPLETED FORM TO (705) 476-7177 for the Gastroenterology Group
OR FAX TO (705) 476-6543 for the General Surgery Group