CHAMPLAIN GI ENDOSCOPY CENTRAL INTAKE

Cancer Screening Related Colonoscopy Referral

Please fax the completed form to: **1 (855) 702-1967**

NOTE: *At this time, central intake will NOT accept referrals for investigation of symptoms or abnormal findings other than FIT*

QUEENSWAY CARLETON HOSPITAL | MONTFORT HOSPITAL | THE OTTAWA HOSPITAL | HAWKESBURY GENERAL HOSPITAL
KEMPTVILLE DISTRICT HOSPITAL | PEMBROKE REGIONAL HOSPITAL | CARLETON PLACE HOSPITAL | CORNWALL COMMUNITY HOSPITAL
ARNPRIOR REGIONAL HOSPITAL | RENFREW VICTORIA HOSPITAL | GLENGARRY MEMORIAL HOSPITAL | WINCHESTER DISTRICT MEMORIAL HOSPITAL

PATIENT INFORMATION

First Name:	**Last Name:**	**Gender:** ☐ M ☐ F ☐ Other
Address:	**City:**	**Postal Code:**
DOB (yyyy/mm/dd):	**Main Language Spoken:** ☐ English ☐ French ☐ Other: _____ ☐ Interpreter required	**Ontario Health Card #**
Mobility Issues: ☐ Requires wheelchair ☐ Requires lift for transfer		
Preferred Phone #:	**Email:**	**Preferred Communication**: ☐ Phone ☐ Email

Consent: Patient able to give consent ☐ Yes ☐ No
If no, SDM/POA/Public Guardian or Trustee: Name_____ Phone # _____

INDICATION FOR COLONOSCOPY - TEST REQUEST

Please select one indication and check appropriate box(es) below

☐ Abnormal FIT **(PLEASE ATTACH REPORT)**	Date of Abnormal FIT: _____
☐ Screening	Reason for Screening: ☐ First degree relative with colorectal cancer Relationship to first degree relatives(s): ☐ Mother ☐ Father ☐ Brother ☐ Sister ☐ Other Age(s) of first-degree relative(s) when diagnosed: _____ ☐ Hereditary cancer syndrome (Specify_____) ☐ First-degree relative(s) with documented advanced polyps before age 60
☐ Surveillance	Reason for Surveillance: ☐ Prior Hx of colorectal polyps (Date of prior colonoscopy_____) ☐ Prior Hx of colorectal cancer (Date of cancer surgery_____) ☐ Hx of IBD colitis of at least 8-year duration (Year of Diagnosis_____) ○ Ulcerative Colitis ○ Crohn's Disease

PATIENT HISTORY RELEVANT TO TRIAGE

Significant Medical History: (CUMULATIVE PATIENT PROFILE MUST BE INCLUDED FOR EACH REFERRAL)

☐ None
☐ Anticoagulants
☐ Antiplatelet agent other than aspirin
☐ BMI greater than 50
☐ Diabetes on insulin or medications
☐ Internal defibrillator
☐ Pacemaker
☐ Severe obstructive sleep apnea on CPAP

Other: _____

RELEVANT PREVIOUS PROCEDURES

☐ Colonoscopy
☐ Sigmoidoscopy

Is the patient currently being monitored by another specialist for this or any gastrointestinal issues: ☐ No ☐ Yes ☐ Not Sure

☐ Previous colonoscopy report and pathology results attached

IF AVAILABLE, PLEASE ATTACH PRIOR COLONOSCOPY & PATHOLOGY REPORTS TO THIS REFERRAL

IF NO REPORT, PLEASE PROVIDE THE YEAR OF PREVIOUS COLONOSCOPY AND NAME OF ENDOSCOPIST/FACILITY

Year_____ Name of Endoscopist_____ Facility _____

CONSULTATION REQUEST OPTIONS

☐ First available date/Physician ☐ Preferred Physician:_____ ☐ Preferred Hospital: _____

REFERRING PHYSICIAN/NURSE PRACTITIONER

Name:	CPSO #:	Billing #:
Telephone:	FAX:	
Signature:	Date:	