Hôpital Régional de Pembroke Regional Hospital

Colon Cancer Check Program Referral Form

To submit referral fax to Pembroke Regional Hospital, OR Fax: 613-732-6345

Indication for referral:

This screening is applicable for patients 50 to 74 years who have a positive FIT. **Attach patient's FIT results to this referral.**

Continue to use your existing specialist referral channels for patients presenting with symptoms requiring investigation OR patients requiring colonoscopy for other reasons, including family history.

First Name: **Last Name:**	**Gender:** ☐ **Male** ☐ **Female**
Address:	**DOB (max 74 years):**
Address 2:	**Home phone:**
Family physician:	**Work phone:**
Health card #: **Version:**	**Mobile phone:**

Is the patient capable of giving their own informed consent? ☐ **Yes** ☐ **No**

Is the patient aware of positive result? ☐ **Yes** ☐ **No**

Main language spoken: ☐ **English** ☐ **French** ☐ **Other:** _____

If the patient does not read/speak English or French, he/she should be accompanied by an interpreter at the time of the appointment.

SIGNIFICANT MEDICAL HISTORY: (Please complete entire section)

Section 1:			**Section 2:**		
Renal Failure (EGFR >30%)	☐ Yes†	☐ No†	Respiratory Disease	☐ Yes†	☐ No†
Prosthetic Heart Valve	☐ Yes†	☐ No†	Diabetes Mellitus on Medication	☐ Yes†	☐ No†
Anticoagulation/Coagulation Disorder	☐ Yes†	☐ No†	Heart Disease	☐ Yes†	☐ No†
Pacemaker	☐ Yes†	☐ No†	Sleep Apnea	☐ Yes†	☐ No†
			Other Medical Conditions	☐ Yes†	☐ No†
Allergies:			Significant Past Medical History:		
Referring Doctor: CPSO#: Phone: Fax: Signature:			Medications:		

HOSPITAL USE ONLY: **Colonoscopy Screening Appointment Date:** _____

Patient notified ☐

Form faxed to Surgeon Office ☐

Form sent to Pre-operative Clerk ☐