

**Fecal Immunochemical Test (FIT)  
Positive Colonoscopy  
Referral Form**

**Please complete ALL information and fax to: 416-530-6299  
(Telephone: 416-530-6156)**

**PATIENT'S PERSONAL INFORMATION (or apply patient label)**

Name:					
Address:			Apt#	City/Town:	
Postal Code:	Home phone:		Permission to contact patient at this number?		
	Alternate phone:		<input type="checkbox"/> Yes <input type="checkbox"/> No		
Date of Birth: (yyyy/mm/dd)	Age:	Sex: <input type="checkbox"/> F <input type="checkbox"/> M	Health Card Number:	Version	
Special Considerations (interpreter required, hearing/visual impairment):					
Patient aware of referral <input type="checkbox"/> Yes <input type="checkbox"/> No      POA/SDM: <input type="checkbox"/> Yes <input type="checkbox"/> No					

**INDICATION FOR FIT+ COLONOSCOPY**

<input type="checkbox"/> Fecal Immunochemical Test (FIT) positive result <input type="checkbox"/> Copy of test result attached <u>Comments</u> :	Date of Test:
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**PATIENT MEDICAL HISTORY**

**Colonoscopy History:**  
Has the patient had a previous colonoscopy?  Yes  No      If yes, provide available operative/pathology reports.

**Medications:**

Anticoagulants: <input type="checkbox"/> Yes <input type="checkbox"/> No	Indication: _____
Antiplatelets: <input type="checkbox"/> Yes <input type="checkbox"/> No	Indication: _____
Aspirin: <input type="checkbox"/> Yes <input type="checkbox"/> No	Cardiac defibrillator: <input type="checkbox"/> Yes <input type="checkbox"/> No
NSAIDs: <input type="checkbox"/> Yes <input type="checkbox"/> No	Severe heart failure Class 4: <input type="checkbox"/> Yes <input type="checkbox"/> No
Oxygen dependent COPD: <input type="checkbox"/> Yes <input type="checkbox"/> No	Renal insufficiency: <input type="checkbox"/> Yes <input type="checkbox"/> No
Sleep apnea with CPAP: <input type="checkbox"/> Yes <input type="checkbox"/> No	Insulin: <input type="checkbox"/> Yes <input type="checkbox"/> No
Cardiac pacemaker: <input type="checkbox"/> Yes <input type="checkbox"/> No	Mobility problems: <input type="checkbox"/> Yes <input type="checkbox"/> No
Other: _____	

**REFERRAL INFORMATION (to be completed and signed by the referring physician)**

Referring Physician:	Billing#	Tel#	Fax#
<b>Signature of Referring Physician (mandatory):</b>			

**SJHC GI ENDO OFFICE USE ONLY**

Triage By (initials):	Date referral received:	Appointment date assigned:
Physician assigned:	Physician/office notified (date):	
MRN:	Procedure Time:	Actual Procedure date: