

FIT POSITIVE

DIAGNOSTIC ASSESSMENT REFERRAL FORM
FIT Coordinator Telephone: 416-864-6060 Ext. 2765
Fax: 416-864-5250

Please note – Referrals are triaged and booked by Physician Offices

PATIENT INFORMATION			
Last Name	First Name	Date of Birth:	Gender: <input type="checkbox"/> M <input type="checkbox"/> F
Health Card#	Version Code:	Previous SMH Patient: <input type="checkbox"/> YES <input type="checkbox"/> NO MRN: if known	
Street Address:	City:	Province:	Postal Code:
Phone: Home	Cell:	Work:	
Alternate Contact Name:	Relationship:	Phone: Home	Other:
Prior Colonoscopy: <input type="checkbox"/> YES <input type="checkbox"/> NO Facility:	Date of Prior Colonoscopy:	Language spoken:	
REFERRAL INFORMATION			
<input type="checkbox"/> Positive FIT Please attach copy of FIT result <input type="checkbox"/> Date of Abnormal Result _____ <ul style="list-style-type: none"> Patients who have an abnormal FIT test will be scoped within 8 weeks 			
Medical History: <input type="checkbox"/> Anticoagulants, ASA, NSAIDS, or natural blood thinners. <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list: _____ <input type="checkbox"/> Current Medications: _____ <input type="checkbox"/> Allergies _____ Cardiac Disorders: <input type="checkbox"/> Hypertension <input type="checkbox"/> Ischemic Heart Disease <input type="checkbox"/> Internal/External Pacemaker Respiratory Disorders: <input type="checkbox"/> Asthma <input type="checkbox"/> Sleep Apnea <input type="checkbox"/> Chronic Pulmonary Disease Kidney Disorders: <input type="checkbox"/> Dialysis <input type="checkbox"/> Diabetes Previous Surgeries: <input type="checkbox"/> Colorectal <input type="checkbox"/> Abdominal <input type="checkbox"/> Other _____			
REFERRAL INFORMATION (TO BE COMPLETED AND SIGNED BY REFERRING PHYSICIAN)			
Referring Physician	Billing#	Phone	Fax
Family Physician	Phone		Fax
Signature of Referring Physician (Mandatory)			
Date:(mm/dd/yyyy) _____			
SMH USE ONLY	Date Received:	Procedure Date/Time:	
Colonoscopist:	MRP:		