

Waterloo Wellington Coordinated Colonoscopy Access Program Referral Form



Waterloo Wellington Regional Cancer Program
in partnership with Cancer Care Ontario

The Waterloo Wellington Coordinated Colonoscopy Access Program is intended for **asymptomatic average risk** patients between the ages of 50-74 that have an **abnormal FIT result**.

Referral Date:
<hr/> YYYY MM DD

Patients should be referred directly to a specialist if they have one or more of the following:

- Personal history of colorectal cancer, Crohn's disease (involving the colon), or ulcerative colitis
- Symptoms such as rectal bleeding, persistent change in bowel habits, unexplained weight loss, and iron deficiency anemia
- Colorectal polyps requiring surveillance
- One or more first degree relatives with colorectal cancer

Patient Information (please print)		Referring Physician Information (please print)
Health card number: VC:	Preferred language: <input type="checkbox"/> English <input type="checkbox"/> other:	Name:
	Restricted mobility: <input type="checkbox"/> yes <input type="checkbox"/> no	
Last name:	First name:	Phone:
DOB: _____ YYYY MM DD	Sex:	Fax:
Street Address:	City/town:	Address:
Province:	Postal code:	Email:
Phone (home):	Patient consents to leave message: <input type="checkbox"/> yes <input type="checkbox"/> no	Billing number:
Phone (cell):	Patient consents to leave message: <input type="checkbox"/> yes <input type="checkbox"/> no	
Email:	Patient consents to receive information by email: <input type="checkbox"/> yes <input type="checkbox"/> no	Signature:

Medical History

Please select all that apply and attach relevant reports.

<input type="checkbox"/> Anticoagulation therapy (does not include ASA 81mg)	Name:	Indication:
<input type="checkbox"/> Renal disease	Most recent Serum creatinine:	<input type="checkbox"/> Liver disease
<input type="checkbox"/> Prior stroke or MI	Date: _____ YYYY MM DD	<input type="checkbox"/> Seizure
<input type="checkbox"/> Congestive heart failure <input type="checkbox"/> Chest pain or angina <input type="checkbox"/> Irregular heart beat <input type="checkbox"/> Internal defibrillator or pacemaker	<input type="checkbox"/> Sleep apnea/CPAP <input type="checkbox"/> Asthma <input type="checkbox"/> Severe COPD, emphysema or other severe pulmonary disease	<input type="checkbox"/> History of adverse reaction to sedation/anesthesia <input type="checkbox"/> Previous pelvic or abdominal surgery <input type="checkbox"/> Diabetes: <input type="checkbox"/> Oral hypoglycemic <input type="checkbox"/> Insulin
<input type="checkbox"/> Other relevant comorbidities:		
<input type="checkbox"/> Allergies:		<input type="checkbox"/> NKA

Medications (please attach medication history):

Date of Abnormal FIT Result: _____ YYYY MM DD (please attach FIT result)	<input type="checkbox"/> Book first available colonoscopy date or <input type="checkbox"/> Book colonoscopy with Dr. _____ Please note, if no selection is made, the first available colonoscopy date will be booked.	<input type="checkbox"/> Previous colonoscopy Location: Date: _____ YYYY MM DD (please attach result)	<input type="checkbox"/> Incapable of giving consent for the colonoscopy
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Please send completed referral form by Ocean eReferral or fax

Ocean eReferral	or	Fax: 519-749-4232
Contact Tricia.Wilkerson@ehealthCE.ca to sign up		

For more information, please call: 519-749-4300 ext. 2974. Please note: A complete referral form, medical history, list of medications and FIT result is required to facilitate timely access to colonoscopy.