NOTE: *Incomplete and / or unsigned requisitions will be returned!

PLEASE PRINT CLEARLY
OR AFFIX LABEL WITH COMPLETE INFORMATION

MARKHAM STOUFFVILLE HOSPITAL CORPORATION

Colorectal Cancer Screening Program
Colonoscopy Referral Form

Markham Site Booking Line: (905) 472-7351 Fax: (905) 472-7598

Appointment Date & Time: ____________________

Hospital MRN #: ____________________

Patient Name: ____________________ (Last) ____________________ (First)

Date of Birth: ________ (Day) ________ (Month) ________ (Year) **Sex: F M**

Health Card # ____________________ **Version Code:** ________

Telephone # Home: ____________________

Other Telephone #: ____________________

Date:	Referring MD	Signature	MD Phone #
Additional Reports to:			

Spoken Language if Other Than English	Contact information for translator if required Name:	Phone #

Please note that if your patient does not speak /read English, he/she should be accompanied by an interpreter at the time of appointment

Indication - Patient must be asymptomatic and meet one of the following:

- ☐ **1. Positive FOBT (PF)**
- ☐ **2. A first-degree relative had Colorectal Cancer (FD) Whom** ____________ **Age at DX.** ________
- ☐ **3. Scheduled recall procedure (the 2nd and all subsequent colonoscopies**

Medical History

- ☐ Abnormal Renal Function
  Most recent serum creatinine level: ________
- ☐ Diabetes Mellitus on Medication
  ☐ *Oral Hypoglycemics* ☐ *Insulin* ________
- ☐ Emphysema/Other Severe Pulmonary Disease
- ☐ Heart disease
- ☐ Sleep Apnea
- ☐ Anticoagulation / Coagulation Disorder
- ☐ Endocarditis Prophylaxis required ☐ Y ☐ N
  Indicated only for:
  - ☐ *Prosthetic heart valve*
  - ☐ *Previous history endocarditis*
  - ☐ *Congenital heart defect w / prosthetic material/device within 6 months*
- ☐ History of Adverse Reaction to Sedation or Anesthesia
- ☐ Previous Abdominal / Pelvic Surgery
- ☐ Other: ____________________

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Medications: ☐ NONE

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____

Allergies: ☐ NONE

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____

☐ Past Medical History - see attached summary

Preferred Site: ☐ Markham ☐ Uxbridge

Colonoscopy and Consultation Requested

☐ Next available appointment ☐ Dr: ____________________

COLCSPCRF (12/11) (9711)