RESET FORM

Trillium Health Partners

THP FIT-POSITIVE COLONOSCOPY REFERRAL FORM

Please fax referrals to
905-813-2617

Eligibility for FIT-Positive Colonoscopy: As per Cancer Care Ontario's guidelines, patients referred for a FIT-positive colonoscopy must be 50 - 74 years old and have not received a previous colonoscopy within the last 5 years.

PATIENT INFORMATION

Patient Name (Last Name, First Name)			**Date of FIT-Positive Test Result (DD/MM/YYYY)**
Health Card #	**Gender**		**Medications** ○ Not known ○ List attached
Date of Birth (DD/MM/YYYY)	**Age**		
Street Address			
City	**Province**	**Postal Code**	**Allergies** ○ No known ○ List attached
Home Phone #	**Mobile Phone #**	**Work Phone #**	
Email			

MEDICAL HISTORY

Select Conditions or Past Medical Events

- ☐ **Cardiovascular disease** *(please specify)*:_____
- ☐ **COPD/Asthma**
- ☐ **Diabetes** *(requiring insulin or pills)*
- ☐ **Hemophilia**
- ☐ **Major Surgery within past 6 months** *(please specify)*:_____
- ☐ **Morbidly obese**
- ☐ **Pacemaker/ICD**
- ☐ **Stroke** *(please estimate date of event)*:_____

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Other Notes *(please consider including other relevant details)*

REFERRING PHYSICIAN CONTACT INFORMATION

Physician Name *(Last Name, First Name)*		
Phone #	**Fax #**	**Date of Referral** *(DD/MM/YYYY)*
CPSO#:	**Signature:**	