ST JOSEPH'S
HEALTH CENTRE TORONTO

7 4 1 1 7

Patient ID

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: Alternate phone:		Permission to contact patient at this number? ☐ Yes ☐ No	
Date of Birth: (yyyy/mm/dd)	Age:	Sex: ☐ F ☐ M	Health Card Number:	Version
Special Considerations (interpreter required, hearing/visual impairment):				
Patient aware of referral ☐ Yes ☐ No POA/SDM: ☐ Yes ☐ No				

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

Referring Physician:	Billing#	Tel#	Fax#

INDICATION FOR FIT+ COLONOSCOPY

☐ Fecal Immunochemical Test (FIT) positive result ☐ Copy of test result attached Comments:	Date of Test:

PATIENT MEDICAL HISTORY

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

Medications:

Anticoagulants: ☐ Yes ☐ No	Medication:	Indication:
Antiplatelets: ☐ Yes ☐ No	Medication:	Indication:
Aspirin: ☐ Yes ☐ No	Insulin: ☐ Yes ☐ No	
NSAIDs: ☐ Yes ☐ No	Other:	

Oxygen dependent COPD: ☐ Yes ☐ No Sleep apnea with CPAP: ☐ Yes ☐ No Cardiac pacemaker: ☐ Yes ☐ No	Cardiac defibrillator: ☐ Yes ☐ No Severe heart failure Class 4: ☐ Yes ☐ No Oral anti-diabetic Medication: ☐ Yes ☐ No	Renal insufficiency: ☐ Yes ☐ No Mobility problems: ☐ Yes ☐ No Iron pills: ☐ Yes ☐ No

Signature of Referring physician (mandatory):

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: