St. Michael's
Inspired Care.
Inspiring Science.

FIT POSITIVE

Reset Form

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DIAGNOSTIC ASSESSMENT REFERRAL FORM FOR FIT POSITIVE PATIENTS

Nurse Navigator 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: ☐ M ☐ F
Health Card#	Version Code:	Previous SMH Patient: ☐ YES ☐ NO MRN: if known	
Street Address:	City:	Province:	Postal Code:
Phone: Home	Cell:	Work:	
Alternate Contact Name:	Relationship:	Phone: Home	Other:
Prior Colonoscopy: ☐ YES ☐ NO Facility:	Date of Prior Colonoscopy:	Language spoken:	

REFERRAL INFORMATION

☐ Positive FIT ***Please attach copy of FIT result***

☐ ***Date of Abnormal Result*** _____

- Patients who have an abnormal FIT test will be scoped within 8 weeks

Medical History:

☐ Anticoagulants, ASA, NSAIDS, or natural blood thinners. ☐ Yes ☐ No If yes, list:_____

☐ Current Medications: _____

☐ Allergies _____

Cardiac Disorders: ☐ Hypertension ☐ Ischemic Heart Disease ☐ Internal/External Pacemaker

Respiratory Disorders: ☐ Asthma ☐ Sleep Apnea ☐ Chronic Pulmonary Disease

Kidney Disorders: ☐ Dialysis ☐ Diabetes

Previous Surgeries: ☐ Colorectal ☐ Abdominal ☐ 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:**