

\*\*\* NOTE: Incomplete and / or unsigned requisitions will be returned! OR AFFIX LABEL WITH COMPLETE INFORMATION

MARKHAM STOUFFVILLE HOSPITAL CORPORATION

**REGISTERED NURSE PERFORMED  
FLEXIBLE SIGMOIDOSCOPY  
PROGRAM REFERRAL FORM**

Markham Site Booking Line: (905) 472-7373 ext. 6137

Hospital MRN #: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Last First

Date of Birth: \_\_\_\_\_ Sex: F M

Day Month Year

Health Card # \_\_\_\_\_ Version Code: \_\_\_\_\_

Telephone # Home: \_\_\_\_\_

Other Telephone #: \_\_\_\_\_

Appointment Date & Time: \_\_\_\_\_

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

Spoken Language if other than English	Contact Information for Translator if Required Name:	Phone #
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Medications:	Drug Allergies:

**Eligibility**

Age 50 - 74

Negative FOB test within 2 years. Date completed \_\_\_\_\_  
If no: FOBT kit provided  Yes  No Reason \_\_\_\_\_

No history of inflammatory bowel disease (Crohn's Colitis)

No family history of colorectal cancer

No large bowel symptoms

No previous polyps or history of colorectal cancer

**Is patient currently on Anticoagulant therapy?**  No  Yes  Warfarin  Clopidogrel  Aspirin/Ibuprofen

<b>Does the patient have a history of:</b>		Lung Disease (COPD/Emphysema) <input type="checkbox"/> No <input type="checkbox"/> Yes
Cardiovascular or valvular disease <input type="checkbox"/> No <input type="checkbox"/> Yes	Pacemaker / Implantable Cardiac Defibrillator <input type="checkbox"/> No <input type="checkbox"/> Yes	Cancer <input type="checkbox"/> No <input type="checkbox"/> Yes
Bleeding Disorders <input type="checkbox"/> No <input type="checkbox"/> Yes	Diabetes <input type="checkbox"/> No <input type="checkbox"/> Yes	Previous Abdominal Surgery <input type="checkbox"/> No <input type="checkbox"/> Yes
		Liver or Kidney Disease <input type="checkbox"/> No <input type="checkbox"/> Yes

Comments:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

FOBT  Yes  No  Pending

Flexible Sigmoidoscopy

Colonoscopy

Patient Appointment and Education Information Provided

Consent for Treatment Form (CONT) signed

Follow Up Required

Physician contacted

Date: \_\_\_\_\_

RT / Nurse Signature \_\_\_\_\_ as per medical directive

