NOTE: Incomplete and / or unsigned requistions will be returned

MARKHAM STOUFFVILLE HOSPITAL CORPORATION

REGISTERED NURSE PERFORMED FLEXIBLE SIGMOIDOSCOPY PROGRAM REFERRAL FORM

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

PLEASE PRINT CLEARLY
OR AFFIX LABEL WITH COMPLETE INFORMATION

Hospital MRN #: _____

Patient Name: _____
Last First

Date of Birth: _____ **Sex:** F M
Day Month Year

Health Card # _____ **Version Code:** _____

Phone # (Best Daytime): _____

Alternate #: _____

Email: _____

Appointment Date & Time: _____

Date:	Referring MD	Signature	MD Phone #

Additional Reports to:

Contact information for translator is required (Name & Number)

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 ☐ Asprin/Ibuprofen

Does the patient have a history of:

Cardiovascular or valvular disease	☐ No	☐ Yes	Lung Disease (COPD/Emphysema)	☐ No	☐ Yes
Pacemaker / Implantable Cardiac Defibrillator	☐ No	☐ Yes	Cancer	☐ No	☐ Yes
Bleeding Disorders	☐ No	☐ Yes	Previous Abdominal Surgery	☐ No	☐ Yes
Diabetes	☐ No	☐ Yes	Liver or Kidney Disease	☐ No	☐ 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