NOTE: Incomplete and / or unsigned requisitions will be returned

MARKHAM STOUFFVILLE HOSPITAL CORPORATION

Colorectal Cancer Screening Program
Colonoscopy Referral Form

Markham Site Booking Line: (905) 472-7531
Fax: (905) 472-7598

Uxbridge Site Booking Line: (905) 852-9771 ext.5325
Fax: (905) 862-2005

PLEASE PRINT CLEARLY
OR AFFIX LABEL WITH COMPLETE INFORMATION

Hospital MRN #: _____

Patient Name (Last, First): _____

Date of Birth (DD/MM/YYYY): _____ Sex: F M

Health Card #: _____ Version Code: _____

Address: _____ Postal Code: _____

Telephone # (Best Daytime): _____

Alternate #: _____

Email: _____

Appointment Date & Time: _____

Date:	Referring MD	Signature	MD Phone #

Additional Reports to:

Spoken Language if Other Than English	Contact information for translator if required (Name & Number)

Please note that if your patient does not speak /read English, he/she should be accompanied by an interpreter at the time of appointment

Indication - Patient must be asymptomatic and meet one of the following:

- ☐ **1. Positive FOBT (PF)**
- ☐ **2. A first-degree relative had Colorectal Cancer (FD) Whom**_____ **Age at DX.**_____
- ☐ **3. Scheduled recall procedure (the 2nd and all subsequent colonoscopies**

Medical History

- ☐ Abnormal Renal Function
  *Most recent serum creatinine level:*_____
- ☐ Diabetes Mellitus on Medication
  - ☐ *Oral Hypoglycemics* ☐ *Insulin*_____
- ☐ Emphysema/Other Severe Pulmonary Disease
- ☐ Heart disease
- ☐ Sleep Apnea
- ☐ Anticoagulation / Coagulation Disorder
- ☐ Other:

- ☐ Endocarditis Prophylaxis required ☐ Y ☐ N
  Indicated only for:
  - ☐ *Prosthetic heart valve*
  - ☐ *Previous history endocarditis*
  - ☐ *Congenital heart defect w / prosthetic material/device within 6 months*
- ☐ History of Adverse Reaction to Sedation or Anesthesia
- ☐ Previous Abdominal / Pelvic Surgery

Medications: ☐ NONE

Allergies: ☐ NONE

☐ Past Medical History - see attached summary **Preferred Site:** ☐ Markham ☐ Uxbridge

Colonoscopy and Consultation Requested

☐ Next available appointment ☐ Dr:_____ ☐ Billing #: _____