Colorectal Diagnostic Assessment Program Referral Form

London Health Sciences Centre
Fax: 519-663-3020

St. Joseph's Health Care Centre
Fax: 519-646-6114

**** This referral form is for FIT positive patients only. For all other indications for colonoscopy please send referral directly to the Gastroenterologist or General Surgeon of your choice.**

Patient Name: _____ **HIN:** _____ **VC:** _____

Address: _____ **Date of Birth:** _____

_____ **Phone:** _____**Alternate**_____

Language Spoken: _____ **Translator Required:** Yes ☐ No ☐

Special Needs: (Mobility Restrictions /Other) _____ **Sex:** Male ☐ Female ☐

Is patient capable of giving their own informed consent - Yes ☐ No ☐

Contact - Name _____ Telephone: _____

☐ **FIT Positive lab report must be included**

Significant Medical History – Please (√) below:

☐ Heart Disease ☐ Diabetes Mellitus - Insulin ☐ Oral ☐ ☐ High Blood Pressure

☐ Renal Failure (Creatinine greater than 150) ☐ Respiratory Disease ☐ Prosthetic Heart Valve

Anticoagulation: Yes ☐ No ☐ If yes, please indicate medication: _____

☐ Implantable Devices (please list): _____

Other Medical History:

_____

_____

Current Medication:

_____

_____**Allergies:**

_____

Referring Physician: (please print) _____ **Telephone:** (____)_____

Signature: _____ **Fax:** (___)_____

Referral Date: _____

For Office Use Only Hospital ID _____

Screening Colonoscopy Appointment _____

Revised July 12, 2019