Hamilton Niagara Haldimand Brant Regional Cancer Program
in partnership with Cancer Care Ontario

COMPLEX POLYPS ADJUDICATION REFERRAL – TIER 2

If your referral has not been processed within 5 days, please contact the nurse clinician at: 905-521-2100, ext. 76933

Fax form and accompanying documentation to Hamilton Health Sciences **905-526-0594**

Patient's Last Name | First Name

Address – Street | City | Postal Code

Telephone: ( ) Ext.

Cell Phone: ( )

Date of Birth (yyyy/mm/dd) | Age | Gender ☐ M ☐ F

HIN | Family Physician

Referral Date (yyyy/mm/dd) _____

Referring Physician _____

Physician Signature _____

Hospital: _____ Hospital Email: _____

Phone _____ (ext) _____ OHIP Billing Number _____

☐ Refer to Dr. Tse / Dr. Yaghoobi **or** ☐ Refer to Any EMR Physician

Size	☐ Greater than 3 centimeters	☐ Greater than one-third the luminal circumference
Location	☐ Involvement of the appendiceal orifice	☐ Close proximity to the dentate line
	☐ Involvement of the ileocecal valve	☐ Difficult position for endoscopic resection
	☐ Suspected involvement of a diverticular opening	
Morphology	☐ Non-granular surface	☐ Polyp is not lifting with submucosal injection
	☐ Ulcer in an otherwise benign looking polyp	☐ Depressed component (Paris IIC morphology)
Other	☐ Partial polypectomy/prior attempt at resection	☐ Lesion exceeds perceived skillset
	☐ Other (please identify): _____	

CLINICAL HISTORY: Does patient have any of the following medical conditions?

	No	Yes	Comment
Active alcohol abuse and / or chronic high dose opioid or benzodiazepine utilization?	☐	☐	_____
Coronary Artery Disease with unstable angina or a recent MI (within the past 12 months)	☐	☐	_____
Congestive Heart Failure	☐	☐	_____
Pacemaker / ICD	☐	☐	_____
Lung Disease	☐	☐	_____
Sleep Apnea	☐	☐	_____
Glaucoma	☐	☐	_____
Malignant Hyperthermia	☐	☐	_____
Anticoagulant Therapy	☐	☐	_____
Diabetes	☐	☐	_____
BMI greater than 40	☐	☐	_____

Additional Information:
- Tattoo at: Distal to lesion? ☐ No ☐ Yes **or** Proximal to lesion? ☐ No ☐ Yes
- Was bowel prep adequate at colonoscopy? ☐ No ☐ Yes

Accompanying documentation to fax with this referral:
- Current Medication List
- Consultation notes
- Current Allergy List
- Relevant pathology and/or lab reports

Email jpeg images meeting to: Tier2polypreview@HHSC.CA

Hamilton Health Sciences ("HHS") cannot control what services or systems other providers use and as such the security of outside electronic communication is not guaranteed. Because of this, it is possible that communications sent to and from HHS by external health care providers may be seen by others. Communications that are sent or received by e-mail may not be secure and can potentially be forwarded, intercepted, circulated, copied, stored, accessed, deleted or even changed without your/the patient's knowledge or permission. Additionally, electronic communications can potentially be falsified more easily than handwritten or signed documents.

By signing the below, you acknowledge the risks of electronic communication, that you have discussed these risks with your patient, that the patient has consented to the use of electronic means of communication of their personal health information for the purpose of this e-referral that HHS is not responsible for electronic systems used by other health care providers or third parties, and that HHS cannot control or secure electronic communications outside of the internal HHS system.

☐ I have read and acknowledge the above noted risks of electronic communication, have discussed those risks with my patient, and agree to proceed with the electronic communication of this referral form. _____ Signature

OR ☐ The patient **does not agree** for images to be sent electronically.

(if no consent is received for the emailing of images , the nurse clinician will contact the referring physician)

Please Note: Referrals sent from unsecure sources (e.g. gmail, yahoo, hotmail, etc.) may not be received