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

COLONOSCOPY REFERRAL FORM

INDICATION: ☐ FIT+ ☐ 1st Degree Family History

Referral Date (yyyy/mm/dd) _____

Referring Physician _____

Physician Signature _____

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	

Address: _____ Province _____ Postal Code _____

Phone _____ (ext) _____ OHIP Billing Number _____

REFERRAL TO:

☐ **Brantford General Hospital**
Phone: 519-751-5545
Fax: 519-752-9983

☐ **Haldimand War Memorial Hospital**
Phone: 905-774-7533
Fax: 905-774-7534

☐ **Hamilton Health Sciences**
Phone: 905-521-2100 x 76933
Fax: 905-526-0594

☐ **Joseph Brant Hospital**
Phone: 905-632-3730 x 5563
Fax: 905-681-4961

☐ **Niagara Health**
Phone: 905-378-4647 x 44757
Fax: 905-688-8288

☐ **Norfolk General Hospital**
Phone: 519-426-0130 x 2219
Fax: 519-429-6892

☐ **St. Joseph's Healthcare Hamilton**
Phone: 905-522-1155 x 33289
Fax: 905-540-6514

Your patient may be referred directly for a consultation and colonoscopy at the same visit.
In order to ensure patient safety and suitability for this examination, the following must be completed.

PATIENT HISTORY:

1. Has patient had a prior colonoscopy? ☐ Yes → (fax copy of most recent report(s) with this referral ☐ No
2. Does patient have a history of colon polyps? ☐ Yes → (fax copy of most recent report(s) with this referral ☐ No
3. Does the patient take any of the following agents?
   - ☐ Anticoagulants → *identify medication(s) and indication:* _____ ☐ No
   - ☐ Antiplatelets → *identify medication(s) and indication:* _____ ☐ No
4. Does patient have the following medical conditions?

Coronary artery disease with unstable angina or a recent MI (within the past 12 months)?	☐ Yes	☐ No
Congestive heart failure?	☐ Yes	☐ No
Implanted cardiac pacemaker and / or defibrillator (ICD)?	☐ Yes	☐ No
Diabetes or insulin?	☐ Yes	☐ No
Chronic renal failure (eGFR less than 60 mL/min)?	☐ Yes	☐ No
Significant respiratory disease (COPD, sleep apnea, restrictive lung disease)?	☐ Yes	☐ No
History of adverse reaction to sedation or anaesthesia?	☐ Yes	☐ No
Substance / alcohol use disorder and / or chronic high dose opioid or benzodiazepine utilization?	☐ Yes	☐ No

Accompanying documentation to fax with this referral:
- Current Medication List
- FIT Results
- Current Allergy List
- Previous colonoscopy and pathology reports

Please fax legibly completed referral form and accompanying documentation as identified above.
Incomplete referrals WILL NOT BE PROCESSED