

# Waterloo Wellington Coordinated Colonoscopy Access Program Referral Form

The Waterloo Wellington Coordinated Colonoscopy Access Program is intended for **asymptomatic average risk** patients between the ages of 50-74 that have an **abnormal FIT result**.

Patients should be referred directly to a specialist if they have one or more of the following:

- Personal history of colorectal cancer, Crohn's disease (involving the colon), or ulcerative colitis
- Symptoms such as rectal bleeding, persistent change in bowel habits, unexplained weight loss, and iron deficiency anemia
- Colorectal polyps requiring surveillance
- One or more first degree relatives with colorectal cancer

|                                    |
|------------------------------------|
| <b>Referral Date:</b>              |
| <hr/> YYYY          MM          DD |

## Patient Information (please print) Referring Physician Information (please print)

|  |  |                        |
|--|--|------------------------|
| <b>Health card number:</b><br><b>VC:</b>             | <b>Preferred language:</b> <input type="checkbox"/> English <input type="checkbox"/> other:<br><br><b>Restricted mobility:</b> <input type="checkbox"/> yes <input type="checkbox"/> no    | <b>Name:</b>           |
| <b>Last name:</b>                                    | <b>First name:</b>   | <b>Phone:</b>          |
| <b>DOB:</b><br>_____<br>YYYY          MM          DD | <b>Sex:</b>  | <b>Fax:</b>            |
| <b>Street Address:</b>                               | <b>City/town:</b>  | <b>Address:</b>        |
| <b>Province:</b>                                     | <b>Postal code:</b>  | <b>Email:</b>          |
| <b>Phone (home):</b><br><b>Phone (cell):</b>         | Patient consents to leave message: <input type="checkbox"/> yes <input type="checkbox"/> no<br>Patient consents to leave message: <input type="checkbox"/> yes <input type="checkbox"/> no | <b>Billing number:</b> |
| <b>Email:</b>  | Patient consents to receive information by email:<br><input type="checkbox"/> yes <input type="checkbox"/> no  | <b>Signature:</b>      |

## Medical History

Please select all that apply and attach relevant reports.

|   |   |  |
|---|---|--|
| <input type="checkbox"/> Anticoagulation therapy (does not include ASA 81mg)  | Name: _____   | Indication: _____  |
| <input type="checkbox"/> Renal disease  | Most recent Serum creatinine: _____   | <input type="checkbox"/> Liver disease   |
| <input type="checkbox"/> Prior stroke or MI   | Date: _____<br>YYYY          MM          DD   | <input type="checkbox"/> Seizure   |
| <input type="checkbox"/> Congestive heart failure<br><input type="checkbox"/> Chest pain or angina<br><input type="checkbox"/> Irregular heart beat<br><input type="checkbox"/> Internal defibrillator or pacemaker | <input type="checkbox"/> Sleep apnea/CPAP<br><input type="checkbox"/> Asthma<br><input type="checkbox"/> Severe COPD, emphysema or other severe pulmonary disease | <input type="checkbox"/> History of adverse reaction to sedation/anesthesia<br><input type="checkbox"/> Previous pelvic or abdominal surgery |
| <input type="checkbox"/> Other relevant comorbidities:  |   | <input type="checkbox"/> Diabetes:<br><input type="checkbox"/> Oral hypoglycemic<br><input type="checkbox"/> Insulin                         |
| <input type="checkbox"/> Allergies:   |   | <input type="checkbox"/> NKA   |

**Medications** (please attach medication history):

|   |                                     |                                    |   |   |  |
|---|-------------------------------------|------------------------------------|---|---|--|
| <table border="1" style="width: 100%;"> <tr> <td style="text-align: center;"><b>Date of Abnormal FIT Result:</b></td> </tr> <tr> <td style="text-align: center;"> <hr/>                             YYYY          MM          DD                         </td> </tr> </table> <p style="text-align: center;">(please attach FIT result)</p> | <b>Date of Abnormal FIT Result:</b> | <hr/> YYYY          MM          DD | <input type="checkbox"/> Book first available colonoscopy date or<br><input type="checkbox"/> Book colonoscopy with Dr. _____<br><br>Please note, if no selection is made, the first available colonoscopy date will be booked. | <input type="checkbox"/> Previous colonoscopy<br>Location: _____<br>Date: _____<br>YYYY          MM          DD<br>(please attach result) | <input type="checkbox"/> Incapable of giving consent for the colonoscopy |
| <b>Date of Abnormal FIT Result:</b>   |                                     |                                    |   |   |  |
| <hr/> YYYY          MM          DD  |                                     |                                    |   |   |  |

**Please send completed referral form by Ocean eReferral or fax**

|   |           |                          |
|---|-----------|--------------------------|
| <b>Ocean eReferral</b>  | <b>or</b> | <b>Fax: 519-749-4232</b> |
| Contact <a href="mailto:Tricia.Wilkerson@ehealthCE.ca">Tricia.Wilkerson@ehealthCE.ca</a> to sign up |           |                          |

For more information, please call: 519-749-4300 ext. 2974. Please note: A complete referral form, medical history, list of medications and FIT result is required to facilitate timely access to colonoscopy.