waterloo wellington regional cancer program
in partnership with cancer care ontario

NURSE PERFORMED FLEXIBLE SIGMOIDOSCOPY REFERRAL FORM

PATIENT INFORMATION	
Name:	Date of Birth (dd/mm/yyyy):
Sex: □ Female □ Male	
Referral date (dd/mm/yyyy):	OHIP # and Version code:
Address: _____ _____ _____	Phone Number: Home:_____ Business: _____

PATIENT ELIGIBILITY CHECKLIST

□ Age 50 – 74
□ No previous bowel cancer
□ No previous polyps
□ No family history of bowel cancer
□ No history of inflammatory bowel disease or rectal bleeding
□ Patient is aware this is an RN flexible sigmoidoscopy program under indirect physician supervision

NOTE: PATIENT NOT MEETING THE ABOVE CRITERIA SHOULD BE REFERRED FOR A COLONOSCOPY

PHYSICIAN INFORMATION	
Name/Signature:	Phone:
Address:	Fax:

FAX TO: 519-749-6941