



**Please complete and fax to 519-749-4232.  
DO NOT REFER UNTIL PATIENT NOTIFIED OF REFERRAL**

Name:			
Date of birth: ____/____/____ yyyy      mm      dd	Health Card Number:	Version:	Sex: <input type="checkbox"/> F <input type="checkbox"/> M
Address:			
City:		Postal Code:	
Home Phone#:		Other #:	

Patients with these conditions cannot be accepted into RCN, please direct your referral to a gastroenterologist or general surgeon:

- Prosthetic valve, previous endocarditis, complex congenital heart disease, cardiac defibrillator
- Severe COPD requiring oxygen
- Anticoagulation Therapy (ASA & NSAIDS accepted)
- Over the age of 75
- Renal Dysfunction requiring Dialysis
- Cirrhosis of the liver
- Inability to give consent

<p><b>Referral Criteria:</b></p> <p><input type="checkbox"/> Positive FOBT from routine screening (ages 50-74 only) Please attach copy of FOBT result</p> <p><input type="checkbox"/> First-degree relative diagnosed with colorectal cancer Patient must be ≥ 50 yrs of age, <b>OR</b> 10 yrs &lt; the earliest age of diagnosis of the first degree relative</p>	<p><b>Symptomatic Referral Criteria:</b></p> <p><input type="checkbox"/> Palpable rectal mass</p> <p><input type="checkbox"/> Palpable abdominal mass</p> <p><input type="checkbox"/> Abnormal imaging suggesting a mass (attach report)</p> <p><input type="checkbox"/> Other (2 or more as per CCO guidelines)</p> <p><input type="checkbox"/> Anemia                      <input type="checkbox"/> Change in bowel habits   <input type="checkbox"/> Weight loss</p> <p><input type="checkbox"/> Rectal bleeding   <input type="checkbox"/> Abdominal discomfort   <input type="checkbox"/> Perianal symptoms</p>
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**PATIENT MEDICAL HISTORY (attach patient profile if using EMR)**

**Colonoscopy History:**  
Has the patient had a previous colonoscopy?  Yes\*  No If yes, please provide available operative/pathology reports.  
*\*The Regional Colonoscopy Network (RCN) cannot accept patients that have had a precancerous lesion (i.e. adenomatous polyp) found during a previous colonoscopy. If unsure call 519-749-4370 ext. 2974*

**Check the following if appropriate:**

<input type="checkbox"/> Aspirin	<input type="checkbox"/> CVA/TIA	<input type="checkbox"/> Coagulation Disorder	<input type="checkbox"/> COPD/severe asthma
<input type="checkbox"/> Pacemaker	<input type="checkbox"/> MI/Angina	<input type="checkbox"/> Diabetes - Type I <input type="checkbox"/> or Type II <input type="checkbox"/>	<input type="checkbox"/> CHF
<input type="checkbox"/> Hx Kidney stones	<input type="checkbox"/> Renal Impairment	<input type="checkbox"/> Elevated Creatinine	<input type="checkbox"/> Hx. Seizure Disorder

**Relevant History:**

**Current Medications:**

**Allergies (specify):**

**Signature of Referring physician (mandatory):** \_\_\_\_\_

Referring Physician: \_\_\_\_\_

Doctors Billing #:	Tel #:	Fax #:
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**RCN USE ONLY**

Scheduled Endoscopist:	Received: ____/____/____ yyyy      mm      dd	Contact with patient: ____/____/____ yyyy      mm      dd
Phone assessment: ____/____/____ yyyy      mm      dd	Procedure Date: ____/____/____ Time: _____ yyyy      mm      dd	Endoscopist consult: (if applicable) ____/____/____ yyyy      mm      dd
Information Package Forwarded: <input type="checkbox"/> Mail <input type="checkbox"/> Fax <input type="checkbox"/> Email	Comments: Hospital Site: <input type="checkbox"/> Grand River <input type="checkbox"/> St. Mary's <input type="checkbox"/> Guelph General <input type="checkbox"/> Mount Forest	MRN: _____ Notes: _____