waterloo wellington
regional cancer program
in partnership with cancer care ontario

REGIONAL COLONOSCOPY NETWORK

Please complete ALL information and fax to: 519-749-4232
(Telephone: 519-749-4370 ext. 2974)

PATIENT'S PERSONAL INFORMATION (or affix patient demographics sticker)

Name:				
Address:		Apt. #:	City, town, village:	
Postal code:	Home phone #: Business/other phone #:		Permission to contact patient at this number? ☐ Yes ☐ No	
Date of birth: ____ / ____ / ____ (Year / Month / Day)	Age:	Sex: ☐ F ☐ M	Health Card Number:	Version code / Exp date:
Special Considerations (interpreter required, hearing/ visual impairment)				

REFERRAL INFORMATION (To be completed and signed by referring physician):

Referring physician:	Doctors Billing #	Tel #:	Fax #:

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 ● Renal Dysfunction requiring Dialysis
● Anticoagulation Therapy (ASA & NSAIDS accepted)
● Severe COPD requiring oxygen ● Cardiac Defibrillator ● Cirrhosis of the liver ● Inability to give consent

ColonCancerCheck Referral Criteria:

☐ Positive FOBT from routine screening (age 50-74 only)
please attach copy of FOBT result

☐ First-degree relative diagnosed with colorectal cancer
pt. must be ≥ 40 yrs of age, **OR**
10 yrs < the earliest age of diagnosis
of the first degree relative

Relevant History:

Symptomatic Referral Criteria:

☐ Palpable rectal mass
☐ Palpable abdominal mass
☐ Abnormal imaging suggesting a mass
*attach imaging report
☐ unexplained IDA
males hgb≤ 110g/L
menopausal females hgb ≤ 100g/L
☐ Other (Specify):

Relevant History:

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

Current medications:_____

Allergies (specify):_____

Check following if appropriate:

☐ Aspirin	☐ CVA/TIA	☐ Coagulation Disorder	☐ COPD/severe asthma
☐ Pacemaker	☐ MI/Angina	☐ Diabetes - Type I ☐ or Type II ☐	☐ CHF
☐ Hx Kidney stones	☐ Renal Impairment	☐ Elevated Creatinine	☐ Hx. Seizure Disorder

Signature of Referring physician (mandatory):

RCN USE ONLY

Physician performing procedure:	Date received: ____ / ____ / ____ (Year / Month / Day)	Initial contact with patient: ____ / ____ / ____ (Year / Month / Day)	
Date telephone assessment scheduled: ____ / ____ / ____ (Year / Month / Day)	Procedure Date: ____ / ____ / ____ (Year / Month / Day)	Procedure Time:	MRN:
Information Package Forwarded: ☐ Mail ☐ Fax ☐ Email	Endoscopist Contacted re: consult (if applicable) ____ / ____ / ____ (Year / Month / Day)	Hospital Site: ☐ Grand River ☐St. Mary's ☐Guelph General ☐Mount Forest	