Waterloo Wellington
Regional Cancer Program
in partnership with Cancer Care Ontario

REGIONAL COLONOSCOPY NETWORK

Phone: 519-749-4370 ext. 2974
Fax: 519-749-4232

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: ☐ F ☐ 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
- Renal Dysfunction requiring Dialysis
- Anticoagulation Therapy (ASA & NSAIDS accepted)
- Cirrhosis of the liver
- Inability to give consent
- Over the age of 75

Referral Criteria:

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

☐ First-degree relative diagnosed with colorectal cancer
Patient must be ≥ 50 yrs of age, ***OR*** 10 yrs < the earliest age of diagnosis of the first degree relative

Symptomatic Referral Criteria:

☐ Palpable rectal mass
☐ Palpable abdominal mass
☐ Abnormal imaging suggesting a mass (attach report)
☐ Other (2 or more as per CCO guidelines)
☐ Anemia ☐ Change in bowel habits ☐ Weight loss
☐ Rectal bleeding ☐ Abdominal discomfort ☐ Perianal symptoms

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:

☐ 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

Relevant History:

Current Medications:

Allergies (specify):

Signature of Referring physician (mandatory):

Referring Physician:		
Doctors Billing #:	Tel #:	Fax #:

RCN USE ONLY

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