Waterloo Wellington Coordinated Colonoscopy Access Program Referral Form

Waterloo Wellington Regional Cancer Program
in partnership with Cancer Care Ontario

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

Referral Date:

_____
YYYY MM DD

Patient Information (please print)

Health card number: **VC:**	**Preferred language:** ☐ English ☐ other: **Restricted mobility:** ☐ yes ☐ no	**Referring Physician Information (please print)** **Name:**
Last name:	**First name:**	**Phone:**
DOB: _____ YYYY MM DD	**Sex:**	**Fax:**
Street Address:	**City/town:**	**Address:**
Province:	**Postal code:**	**Email:**
Phone (home): **Phone (cell):**	Patient consents to leave message: ☐ yes ☐ no Patient consents to leave message: ☐ yes ☐ no	**Billing number:**
Email:	Patient consents to receive information by email: ☐ yes ☐ no	**Signature:**

Medical History

Please select all that apply and attach relevant reports.

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

Medications (please attach medication history):

Date of Abnormal FIT Result: _____ YYYY MM DD (please attach FIT result)	☐ Book first available colonoscopy date or ☐ Book colonoscopy with Dr. _____ Please note, if no selection is made, the first available colonoscopy date will be booked.	☐ Previous colonoscopy Location: Date: _____ YYYY MM DD (please attach result)	☐ Incapable of giving consent for the colonoscopy

Please send completed referral form by Ocean eReferral or fax

Ocean eReferral **or** **Fax: 519-749-4232**

Contact Tricia.Wilkerson@ehealthCE.ca 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.

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