FIT POSITIVE COLONOSCOPY REFERRAL FORM

COMPLETED FORM TO BE FAXED TO BRANT COMMUNITY HEALTH SYSTEM CENTRAL BOOKING AT **519-751-5569**

INCOMPLETE FORMS WILL BE RETURNED TO PRIMARY HEALTH CARE PROVIDER FOR COMPLETION

Patient Information (complete or affix label)
Patient Name:_____
Address:_____
Health Card Number: _____
Phone number: _____
Alternate Phone Number:_____
Patient email address:_____
Emergency Contact: _____
Emergency Contact Phone #:_____
Language ☐ English ☐ Other: _____
☐ Requires a translator

Fecal Occult Blood Test/Fecal Immunochemical Test Positive Date:
Attach lab report

Current Medications:
☐Current medication list is attached ☐No medications

Medical History:

☐No significant medical history
☐Congestive Heart Failure
☐Post Myocardial Infarction (within 3 months)
☐Pulmonary Embolism/ Deep Vein Thrombosis
☐Cerebrovascular Accident
☐Pacemaker/ Defibrillator
☐Coronary Artery Stent
☐Valvular Heart Disease
☐Mechanical Valve Replacement
☐Cirrhosis
☐Chronic Renal Failure
☐Prosthetic Hardware
☐Atrial Fibrillation
☐Diabetes
☐Sleep Apnea
☐Dementia
☐Chronic Obstructive Pulmonary Disease

☐ **Allergies:** _____

☐ Mobility Concerns (specify):_____

☐ Patient NOT able to consent (specify):_____
☐ Most Responsible/Substitute Decision Maker: _____

Height (cm): _____ Weight (kg): _____ Body Mass Index:_____

Healthcare Provider Review:
☐ The procedure indications have been discussed with the patient

Referring Physician:

_____ _____
SIGNATURE PRINTED NAME AND DESIGNATION

Physician Phone Number:_____ Physician Fax Number:_____

Hospital use only	COPY SENT TO:
Date of Procedure:_____ Time of Procedure:_____ ☐Prep instruction sent to patient ☐ email ☐ post ☐Appointment date / time sent to patient ☐Patient No Show	☐Endoscopist _____ ☐Primary HCP Date:_____