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: DD/MM/YYYY
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	☐ JONES ☐ LIACONIS ☐ SCHNIDER ☐ PAWLIWEC ☐ Primary HCP	☐WANG ☐SOMERTON ☐VANDERBEEK ☐Date:_____	☐ROONEY ☐SHARMA ☐DOWNIE