☐ **Bluewater Health**
Phone: 519-464-4400 ext. 5347
Fax: **519-346-4724**

☐ **Erie Shores Healthcare**
Phone: 519-326-2373 ext. 4136
Fax: **519-322-0041**

☐ **Chatham-Kent Health Alliance**
Phone: 519-437-6125
Fax: **519-437-6126**

☐ **Windsor Regional Hospital**
Phone: 519-985-2695
Fax: **519-985-2681**

☐ **Rose City Endoscopy**
Phone: 519-254-4154
Fax: **519-254-4158**

☐ **Southern Ontario Endoscopy Centre**
Phone: 519-915-9494
Fax: **519-915-9493**

Endoscopy Office Use Only

_____ Date

_____ Time

_____ Physician

Fecal Immunochemical Test (FIT) Positive Referral Form

Reset PRINT

Directions:

Please check each box once completed.

☐ Attach a copy of the positive FIT result received from the lab to a complete, signed copy of the referral form.

☐ Fax to your preferred central intake facility above within one week of receiving the positive FIT result.

Notes:

- Incomplete referral forms, including those without the positive FIT result attached, will not be processed.
- Patients must be scoped within 56 days of a positive FIT result.
- If the patient does not read and/or speak English they they will be accompanied by an interpreter at the time of the appointment.
- Direct any questions to your preferred central intake facility above.

Patient's Information:

_____ First Name _____ Last Name _____ Date of Birth (m/d/y)

Sex: ☐male ☐female ☐unspecified

Telephone: H _____ Alt._____

Address: _____ Street/apt/P.O. _____ City/Town _____ Province _____ Postal Code

_____ Health Card Number _____ Version

Indications: Refer all other indications for colonoscopy directly to specialist's office.

Past Medication History: **Patient is on:** ☐ **Anticoagulants** ☐ **ASA** ☐ **NSAIDS** ☐ **DOACs** ☐ **Natural blood thinners:**

Please list: _____

Cardiac Disorders:	☐ **Ischemic Heart Disease**	☐ **Hypertension**	☐ **Pacemaker/Internal Defibrillator**
Respiratory Disorders:	☐ **Asthma**	☐ **Chronic Obstructive Pulmonary Disease**	
Kidney Disorders:	☐ **Renal Insufficiency**	☐ **Dialysis**	☐ **Diabetes**
Previous Surgeries:	☐ **Abdominal Surgery**	☐ **Gynecological Surgery**	☐ **Colorectal Surgery**

☐ **Other:** _____

Current Medications: _____

☐ None _____

_____

Allergies: ☐ Latex ☐ None ☐ **Other:** _____

☐ Patient incapable of giving informed consent _____ Alternate Contact Name _____ Phone Number

Referring Provider's Information: ☐ MD ☐ NP

_____ First and Last Name (please print) _____ Phone Number _____ Referral Date

_____ Signature (please sign before faxing) _____ Fax Number _____ Date Positive FIT Result Received

PCP: ☐ Same as referring provider ☐ Other: _____ _____ OHIP Billing Number