

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

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

Endoscopy Office Use Only

Date (mm/dd/yyyy)

Time

Physician

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

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

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

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

Fecal Immunochemical Test (FIT) Positive Referral Form

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 need to be accompanied by an interpreter at the time of the appointment.
- Direct any questions to your preferred central intake facility above.

Patient's Information:

_____ Sex: male
 First Name Last Name Date of Birth (mm/dd/yyyy) female Telephone: H _____
 _____ unspecified 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 (mm/dd/yyyy)
 _____ Signature (please sign before faxing) _____ Fax Number _____ Date Positive FIT Result Received (mm/dd/yyyy)
 PCP: Same as referring provider Other: _____
 _____ OHIP Billing Number