Referral Form
Positive Fecal Immunochemical Testing

Fax: 905-815-5133
Referral Inquiries: 905-338-2983

Patients must be 18 years of age at time of referral.

Patients will be scheduled with the **First Available** Endoscopist that performs FIT positive colonoscopies.
The target wait time from FIT postive result to colonscopy is 8 weeks.
Preferred Location for Colonoscopy: □ Closest to Home □ Closest to Primary Care Provider

PATIENT INFORMATION

Gender: _____

Last name: _____ First name: _____

DOB: DD/MM/YYYY OHIP#: _____ VC: _____

Phone: _____ Alternate Phone: _____

Address: _____ City: _____ Postal Code: _____

Email: _____

Services will be provided in English only. Please arrange to bring a family member and/or friend to translate for you if needed.

Barriers to Communication: □ Cognitive Impairment □ Hearing Impairment □ Sight Impairment □ Other _____

LAB REPORT

Please attach FIT Positive report.

MEDICAL HISTORY (please attach cumulative patient profile of medical history)

□ Diabetes	□ Sleep Apnea	□ Morbid Obesity (BMI >40)	□ Asthma/COPD requiring hospitalization
□ CHF	□ Bleeding Disorder	□ Severe Constipation	□ Renal Insufficiency (eGFR____)
□ Cirrhosis	□ Atrial Fibrillation	□ PCI/Stenting in the last 12 months	□ MI/Angina within last 12 months

MEDICATIONS ☐ *Attach List with Name/Dose/Frequency* ☐ *Patient does not take any medications*

Is the patient on anti-coagulant medication? □ NO □YES
If Yes, Name & Dose_____ Reason for treatment _____
Expected Duration _____
IS patient on anti-platelet therapy? □ NO □YES

IMPORTANT INFORMATION

Your patient will be contacted directly by the hospital to book his/her colonoscopy date and will be provided with preparation instructions.
You will receive a consult note upon completion of the procedure.
If your patient is on anticoagulants, your patient will need to schedule an appointment with you 10 days prior to his/her colonoscopy to review the anticoagulant management plan. See back of referral form for guideline.

I hereby refer the above noted patient to a physician specialist for follow-up related to a FIT positive report.

Primary Care Provider Name:

REFERRING PROVIDER INFORMATION: □ MD □ NP

Name (Printed): _____ Phone: _____

Address: _____ Fax: _____

Signature: _____ Billing#: _____ Date: DD/MM/YYYY

ONLY COMPLETED REFERRALS WILL BE ACCEPTED

Halton Healthcare
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Anticoagulant Management Guidelines

Medication	Guideline
ASA	Do not Hold
Plavix, Ticagrelor	Hold for 5 days (unless recent stent or other cardiac risk)
Coumadin	Hold for 5 days (may need bridging with LMWH if mechanical valve or high risk)
NOAC	Hold for 2 days if normal renal function Hold for 4 days if poor EGFR with caveats as for Coumadin

For further reference please see: https://www.giejournal.org/article/S0016-5107(15)02950-8/pdf

PROCEDURE LOCATIONS

Halton Healthcare (GH) Georgetown Hospital 1 Princess Anne Drive Georgetown, ON L7G 2B8	Halton Healthcare (MDH) Milton District Hospital 725 Bronte Street South Milton, ON L9T 9K1	Halton Healthcare (OTMH) Oakville Trafalgar Memorial Hospital 3001 Hospital Gate Oakville, ON L6M 0L8