Colorectal Cancer Screening Referral
North Bay General Surgery Group
Complete and Fax 705-476-6543

Patient Information		
Last Name:	First Name:	DOB:
Health Card #:		Gender:
Address:	City:	Postal Code:
	Phone # (preferred):	
	Phone # (alternative):	
Referring Physician Information		
Referring Physician:	Phone #:	
Billing #:	Fax#:	
Referral Date:	Family Physician:	
Referring Physician Signature:		

Referral To:	
❐ First available Surgeon (OR)	
❐ Patient preferred Surgeon ________________________ *Understand that this may incur a longer wait time*	
Patient Preference *(subject to review of chart and physician preference)*	
❐ Direct to colonoscopy	❐ Office consultation prior to scope

PATIENT MUST BE <u>ASYMPTOMATIC</u> AND MEET <u>ONE</u> OF THE FOLLOWING:
❐ Positive FOBT/FITT *(please submit copy of lab result)*
❐ Family history of colorectal cancer or polyps. *(please describe)* ________________________ ________________________
❐ Surveillance colonoscopy. Date of previous scope ______________ *(please send colonoscopy dictation and pathology)*
❐ Over the age of 50

***Please send any symptomatic colonoscopy referrals using the General Surgery Referral Form**

Patient Medical History (to be completed by referring physician)		
❐ Latex Allergy Allergies (please list): ________________________		
❐ Does the patient have any contact precautions? Please list ________________________		
❐ Pacemaker / ICD		
❐ Diabetic	❐ On oral medication	❐ On insulin
❐ Anticoagulants, please list ________________________ Reason for being on anticoagulants ________________________		
Relevant Medical History and other pertinent information:		
Medical History and Medication List (list or attach cumulative patient profile)		