☐ **Bluewater Health**
Phone: 519-464-4400 ext. 5347 **Fax: 519-464-4454**

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

☐ **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

Endoscopy Central Intake Use Only

Date

Time

Physician

Campus : ☐ Met ☐ Ouellette

Fecal Immunochemical Test (FIT) Positive Referral Form

Directions: 1. Print, sign & fax form to preferred facility, including attachment of positive FIT with referral.
2. Patient needs to be scoped within 56 days of positive FIT result.

Reset **PRINT**

Notes:
- Please submit referral within one week of positive result.
- If patient does not read/speak English then he/she should be accompanied by an interpreter at time of appointment.

◆ Have questions regarding referrals? Contact the preferred facility listed at top of this page for assistance. ◆

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 or natural blood thinners: ☐Yes, list below ☐ No

If yes, 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:

Name | Phone Number | Referral Date

Signature (print & sign before faxing) | OHIP Billing Number

PCP: ☐ Same as referring provider ☐ Other: _____