


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

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

**Endoscopy Central Intake Use Only**

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Date

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Time

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Physician

Campus : Met  
 Ouellette

**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:** 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.

**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: <input type="checkbox"/> male <input type="checkbox"/> female <input type="checkbox"/> unspecified	Telephone: H _____ Alt. _____
Address: _____ Street/apt/P.O.		City/Town	Province	Postal Code
Health Card Number	Version	<b>Indications: Refer all other indications for colonoscopy directly to specialist's office.</b>		

**Past Medication History:** Patient is on anticoagulants, ASA, NSAIDS or natural blood thinners:  Yes, list below  No

If yes, list: \_\_\_\_\_

Cardiac Disorders:	<input type="checkbox"/> Ischemic Heart Disease	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Pacemaker/Internal Defibrillator
Respiratory Disorders:	<input type="checkbox"/> Asthma	<input type="checkbox"/> Chronic Obstructive Pulmonary Disease	
Kidney Disorders:	<input type="checkbox"/> Renal Insufficiency	<input type="checkbox"/> Dialysis	<input type="checkbox"/> Diabetes
Previous Surgeries:	<input type="checkbox"/> Abdominal Surgery	<input type="checkbox"/> Gynecological Surgery	<input type="checkbox"/> Colorectal Surgery
	<input type="checkbox"/> Other: _____		

Current Medications: \_\_\_\_\_  
 None

Allergies:  Latex  Other: \_\_\_\_\_  
 None

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: <input type="checkbox"/> Same as referring provider <input type="checkbox"/> Other: _____		