Erie St. Clair
Regional Cancer Program
Ontario Health (Cancer Care Ontario)

Fecal Immunochemical Test (FIT) Positive Referral Form

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

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

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

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

Endoscopy Office Use Only

_____
Date Received (mm/dd/yyyy):

_____
Endoscopist Assigned

Directions: Please check each of the following boxes once completed.

☐ Attach a copy of the positive FIT result recieved from the lab to a complete, signed copy of the referral form.

☐ Fax to your preferred central intake facility above within **ONE WEEK** of recieving the positive FIT result.

Notes:

- INDICATION OF FORM: FIT+ result - refer all other indications for colonscopy directly to specialist's office.
- Incomplete referral forms, including those without the positive FIT result attached, will not be processed.
- Patients must be scoped within 56 days of a FIT+ result.
- If patient does not read and/or speak English, they must be accompanied by an interpreter at appointment.
- Direct any questions to your preferred central intake facility.

Patient's Information:

_____ First Name _____ Last Name _____ Date of Birth (mm/dd/yyyy)

Sex: ☐ Male ☐ Female ☐ Unspecified

Telephone Number:
H: _____
Alt: _____

_____ Healthcard Number _____ Version Code

Address: _____ Street/apt/P.O _____ City/Town _____ Province _____ Postal Code

Patient is on: ☐ Anticoagulants ☐ ASA ☐ NSAIDS ☐ DOACs ☐ Natural Blood Thinners: _____ (Please list)

Current Medications:
☐ NONE
_____
_____

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 ☐ Colorectal

☐ Other medical history: _____
_____

Allergies: ☐ None ☐ Latex ☐ Other: _____

☐ Patient Incapable of giving informed consent _____ Alternate Contact Name _____ Phone Number

Referring Provider's Information

☐ Physician ☐ Nurse Practitioner

_____ First and Last Name (Please Print) _____ Phone Number _____ Fax Number _____ Referral Date (mm/dd/yyyy)

_____ Signature (please sign before faxing) _____ Date Postive FIT Result Received _____ OHIP Billing Number

Patient's Primary Care Provider: ☐ Same as referring provider ☐ Other: _____