SOUTHLAKE
REGIONAL HEALTH CENTRE

596 Davis Drive
Newmarket, ON L3Y 2P9

Diagnostic Assessment Unit

Health Record #: _____ Complete or place patient label here
Patient Name: *(Print first, last)* _____
DOB: mm / dd / yy Age: _____ ❑ Female ❑ Male
OHIP #: _____ Version Code: _____
Account #: _____ Date of Admission: mm / dd / yy

Colon Cancer Check Referral Form

Please fax to 905-954-3884

Patient Name: *(print first, last)*

Date of Birth mm / dd / yy | **Health Card Number:** | **Version Code:**

Patient Address: Street Number + Name | Apartment

City | Province | Postal Code

Patient Preferred Phone Number: | **Patient Alternate Phone Number:**

Primary Care Practitioner Name: *(print first, last)*

Primary Care Practitioner Phone Number: | **Fax Number:**

MEDICAL HISTORY:

Indication for Colonoscopy: ❑ Positive FOBT ❑ First-degree relative with history of colon cancer

Medical Conditions:

- ❑ Yes ❑ No Valvular Heart disease (Requiring antibiotic prophylaxis)
- ❑ Yes ❑ No Chronic Renal Impairment
- ❑ Yes ❑ No Cardiac Disease (MI/Angina/CABG/PTCA)
- ❑ Yes ❑ No Respiratory Disease
- ❑ Yes ❑ No Sleep Apnea
- ❑ Yes ❑ No Diabetes (on Insulin)
- ❑ Yes ❑ No Joint Replacement

Medications: (the following medications will be held for 5 days prior to procedure)

❑ ASA ❑ Iron ❑ Anticoagulants ❑ Antiplatelet Agents
❑ Other: _____

Allergies: _____
_____ ❑ **No Known Allergies**

Additional Relevant History _____
_____

HOSPITAL USE ONLY

Is patient capable of providing informed consent? ❑ No ❑ Yes, specify _____
Is there a need for specific infection precautions? ❑ No ❑ Yes, specify _____

BY SIGNING THIS FORM, I CONFIRM THAT THIS PATIENT IS AWARE OF THIS REFERRAL

Referring Physician Name: *(print first, last)* | **Billing #:**

Referring Physician Signature: | **Date:** mm / dd / yy

Phone Number: | **Fax Number:**