MICHAEL GARRON HOSPITAL
TORONTO EAST HEALTH NETWORK

Colorectal Cancer Diagnostic Assessment Unit Referral Form

Fax completed form to (416) 469-6361

DATE OF REFERRAL:

REASON FOR REFERRAL TO COLORECTAL CANCER DIAGNOSTIC ASSESSMENT UNIT

[ ] Patient referred after a positive FIT **please specify Date of Positive Test**:_____

REFERRING PHYSICIAN INFORMATION		**PATIENT INFORMATION**	
Name:		Last Name	
Physician Number:	Physician Signature:	First Name	
Address:		Address:	
Phone:	Fax:	OHIP/VC:	
PATIENT SPECIAL CONSIDERATIONS		Day Phone:	Home Phone:
Does patient have any special needs (e.g. language translation?) [ ] No [ ] Yes (Specify):		D.O.B. (dd/mmm/yy):	Sex: [ ] Female [ ] Male
Is patient capable of providing informed consent? [ ] Yes [ ] No (reason):		Primary Contact (Last Name, First Name):	
Any other relevant medical history or contact precautions (i.e. MRSA) to be aware of? [ ] No [ ] Yes: _____ [ ] Preparatory instructions given to patient		Relationship to Patient Best Phone # to Contact Individual	

MEDICAL INFORMATION

ALLERGIES: [ ] No known drug allergies Other: _____

PAST MEDICAL HISTORY:

[ ] Acute medical condition requiring hospitalization in past year:

[ ] Previous colonoscopy: [ ] YES [ ] NO. If yes, When_____; Where:_____ [ ] Attached report

□ **Aortic Stenosis**	□ **COPD**	□ **Diabetes**	□ Renal Insufficiency
□ **MI/ Angina/CABG/PTCA**	□ **Asthma**	□ Hypertension	□ Seizures
□ **Valvular Heart Surgery**	□ Other Respiratory Disease	□ Hypoglycemia	□ Neurological Disease
□ **CHF**	□ Hx of Abdominal Surgery:	□ Hip/ Knee replaced <6mths ago	
□ **Pacemaker**	□ Hx of GI Illness:	□ Kidney Disease	
□ Sleep apnea	□ Hx of Liver Disease		

COMMENT/OTHER:

MEDICATIONS: check any in use

Is patient on: [ ] **anticoagulants,** [ ] **ASA,** [ ] **NSAIDS,** [ ] **Coumadin,** [ ] **Plavix** or other anticoagulants:_____

Other:_____

INTERNAL USE ONLY

MGH NURSE'S INSTRUCTION:			[ ] To OR bookings [ ] To Referring MD
Date Received:	Initial Patient Contact Date:	Procedure Date/Time:	Nurse signature: