WOODSTOCK HOSPITAL
Woodstock, ON

COLONOSCOPY REFERRAL FORM

This form is **not to be** used for scheduling colonoscopy for **Positive FIT or FOBT patients.**
(for positive FIT or FOBT use FIT/FOBT Colonoscopy Referral Fax Form)

Patient Name:	Referring Physician: Signature:
DOB: _____ _____ _____ MMM DD YYYY	Referring Physician Phone Number:
Patient Phone:	Referring Physician Fax Number:
Health Card Number:	Referring Physician Billing Number:
Cerner PIN Number: Other Insurance:	Date of Referral:_____ _____ _____ MMM DD YYYY

Reason for colonoscopy:

- ☐ Patient is symptomatic (SA)
- ☐ Surveillance for colorectal cancer (CN)
- ☐ Other screening

Current Medication List:	Special Concerns or Comments: (ie medical alerts, nursing home, non–ambulatory wheelchair or stretcher)

Fax completed referral form to Admitting Office at: 519–421–4243
Incomplete forms will be faxed back to your office

Woodstock Hospital Booking Office Use

Booking staff completed date: _____ _____ _____ MMM DD yyyy	Referral booked with Dr. _____