WOODSTOCK HOSPITAL
Woodstock, ON

COLONOSCOPY REFERRAL FORM
FECAL IMMUNOCHEMICAL (FIT)
FECAL OCCULT BLOOD TEST (FOBT)

This form is **only** to be used for scheduling colonoscopy for **Positive FIT or FOBT patients**

Fax FIT or FOBT referral form to Booking Office at 519–421–4238

*****Please include patient's history and current medication list with this referral*****

Indication for Referral: ☐ Abnormal FIT ☐ Abnormal FOBT	Date of Positive FIT/FOBT:	Date of Referral:

PATIENT INFORMATION

Last Name			
First Name			Date of Birth:
Address	City	Province	Postal Code
Health Card Number	Phone	Email Address	

CURRENT HEALTH STATUS

Is the patient experiencing any symptoms? ☐ Yes ☐ No

Please describe any symptoms:

CURRENT MEDICAL HISTORY (please include all pertinent lab and diagnostic information) ☐ Medical history attached

☐ No significant medical history	☐ Post stroke	☐ Type 1 Diabetes ☐ Type 2 Diabetes
☐ Congestive Heart Failure	☐ Emphysema	☐ Uncontrolled hypertension
☐ Post MI	☐ COPD	☐ Sleep Apnea
☐ Pacemaker/mechanical valve	☐ Abnormal renal function	☐ Dementia
☐ Atrial fibrillation	☐ Cirrhosis	☐ Seizure Disorder

ALLERGIES: ☐ Yes ☐ No

Other Concerns:

Mobility Issues: ☐ Yes ☐ No If yes please describe: _____

Interpreter Needed: ☐ Yes ☐ No If yes, provide details: _____

Care provider or attendant required: ☐ Yes ☐ No

Further information: _____

CURRENT MEDICATIONS

☐ No medications	☐ Other medications (list):
☐ Oral hypoglycemic	_____
☐ Insulin (specify): _____	_____
☐ Anticoagulant (specify): _____	_____
☐ NSAIDS/Platelet Inhibitor medications (specify):	☐ Medication list attached

REFERRING CARE PROVIDER INFORMATION

Address	City	Postal Code
Fax	Phone	Extension
Name	Signature	OHIP Billing #

Woodstock Hospital Booking Office Use

Booking staff completed date: _____ _____ _____ (MMM DD yyyy)	Referral booked with Dr. _____
	Procedure Date: _____ _____ _____ (MMM DD yyyy) Time: _____