Scarborough Health Network
Fecal Immunochemical Test
[FIT]
Screening Program
Referral Form

Phone: 416-495-2552 Fax: 416-495-2488

Allergies

☐ **No Known Allergies** ☐ **Allergies:**_____

1. Patient Information

First Name: _____ **Last Name:** _____ **Gender:** ☐ **Male** ☐ **Female**

DOB: _____/_____/_____
vvvv mm dav

Address: _____ **Phone (H):** _____-_____-_____

_____ **Phone (C):** _____-_____-_____

Health Card: _____ **Version:**_____ **Phone (W):** _____-_____-_____

☐ **Patient incapable of giving their own informed consent**

*** For safety reasons, all patients are to be accompanied by a caregiver for transportation upon discharge***

2. Past Medical History (to be completed by family physician)

☐ **Abnormal Renal Function**
Most recent serum creatinine level: _____

☐ **Diabetes Mellitus Type 1 Insulin:**_____

☐ **Diabetes Mellitus Type 2 Insulin:**_____

☐ **Emphysema/Other Severe Pulmonary Disease**

☐ **Heart Disease**

Medications: ☐ **None**

_____

_____

_____

☐ **Anticoagulation/Coagulation Disorder**
indication:_____

☐ **History of adverse reaction to sedation or Anesthesia**

☐ **Patient using prophylactic antibiotics**

☐ **Previous Abdominal/Pelvic Surgery**

Other:_____

_____

☐ **Medication Allergies**_____

_____

3. Provider Information

Referring Physician: _____ **Signature:** _____

Phone Number: _____ **Physician Billing #:** _____

Date of referral: _____ ☐ **Next available clinic** ☐ **Dr.** _____

4. Hospital Use Only

Colonoscopy / Consultation Appointment: Date:_____ **Time:** _____

Our unit clerical associate will contact your patient with the appointment date and time