Waterloo Wellington Regional Cancer Program
Ontario Health (Cancer Care Ontario)

Waterloo Wellington Coordinated Colonoscopy Access Program Referral Form

The Waterloo Wellington Coordinated Colonoscopy Access Program is intended for **asymptomatic average risk** patients between the ages of 50-74 that have an **abnormal FIT result**.

Patients should be referred directly to a specialist if they have one or more of the following:

- Personal history of colorectal cancer, Crohn's disease (involving the colon), or ulcerative colitis
- Symptoms such as rectal bleeding, persistent change in bowel habits, unexplained weight loss, and iron deficiency anemia
- Colorectal polyps requiring surveillance
- One or more first degree relatives with colorectal cancer

Referral Date:
YYYY MM DD

Patient Information

Health card number:	**Preferred language:** ☐ English ☐ other: **Restricted mobility:** ☐ yes ☐ no	**Name:**
Last name:	**First name:**	**Phone:**
DOB: YYYY MM DD	**Sex:**	**Fax:**
Street Address:	**City/town:**	**Address:**
Province:	**Postal code:**	**Email:**
Phone (home): **Phone (cell):**	Patient consents to leave message: ☐ yes ☐ no Patient consents to receive information by email: ☐ yes ☐ no	**Billing number:**
Email:		**Signature:**

Medical History

Please select all that apply and attach relevant reports.

☐ Anticoagulation therapy (does not include ASA 81mg) Name: Indication:

☐ Renal disease Most recent Serum creatinine: ☐ Liver disease

☐ Prior stroke or MI Date: YYYY MM DD ☐ Seizure

☐ Congestive heart failure ☐ Chest pain or angina ☐ Irregular heart beat ☐ Internal defibrillator or pacemaker	☐ Sleep apnea/CPAP ☐ Asthma ☐ Severe COPD, emphysema or other severe pulmonary disease	☐ History of adverse reaction to sedation/anesthesia	☐ Previous pelvic or abdominal surgery	☐ Diabetes: ☐ Oral hypoglycemic ☐ Insulin

☐ Other relevant comorbidities:

☐ Allergies: ☐ NKA

Medications (please attach medication history):

Date of Abnormal FIT Result:
YYYY MM DD
(please attach FIT result)

☐ Book first available colonoscopy date
or
☐ Book colonoscopy with Dr. _____
Please note, if no selection is made, the first available colonoscopy date will be booked.

☐ Previous colonoscopy
Location:
Date:
YYYY MM DD
(please attach result)

☐ Incapable of giving consent for the colonoscopy

Please send completed referral form by Ocean eReferral or fax

Ocean eReferral
To sign up, please visit: https://www.ontariohealth.ca/digital/innovations/ereferral

or

Fax: 519-749-4232

For more information, please call: 519-749-4300 ext. 2974. Please note: A complete referral form, medical history, list of medications and FIT result is required to facilitate timely access to colonoscopy.

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