

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 45-74 that have an **abnormal FIT result**.

Requisitions will be declined by the WWCCAP under the following conditions:

- FIT result older than 2 years (invalid as per Ontario Health)
- History of Crohn's disease or Ulcerative Colitis (refer to physician managing this instead)
- Had a colonoscopy within the past 3 years (refer to the original endoscopist instead)

Referral Date:

YYYY MM DD

Patient Information

Health card number:	Preferred language: English other: _____	Name:
	Restricted mobility: yes no	
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
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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.