Sunnybrook
HEALTH SCIENCES CENTRE

PATIENT IDENTIFICATION

FIT + Colonoscopy Referral Form

Diagnostic Assessment Program

Phone: 416-480-4318 Fax: 416-480-4403
colonoscopy.dap@sunnybrook.ca

Referral Date (YYYY/MM/DD):_____/_____/_____

PATIENT INFORMATION

Last Name: _____ First Name: _____ DOB: _____

OHIP card: _____ Home phone number: _____

Address: _____City/Province: _____ Postal code: _____

Email address: _____ ☐ Check to confirm patient consent to receive emails

Cell phone number: _____ ☐ Check to confirm patient consent to receive text messages

PHYSICIAN INFORMATION

Referring Physician: _____ OHIP billing #: _____

Bus. Tel: _____ Fax: _____

REFERRAL FOR FIT+ patients

☐ FIT+ Date of FIT+ result (YYYY/MM/DD):_____/_____/_____

Your patient will receive a colonoscopy within 8 weeks and you will receive a faxed report on the day of the colonoscopy.

MEDICAL HISTORY AND/OR OTHER PERTINENT INFORMATION

☐ Patient is diabetic

☐ Patient is on anti-coagulants

Other pertinent medical history:

_____

_____

NOTE: THIS IS AN EXPEDITED PROGRAM

Please ensure your patient can attend the appointments which will be scheduled within the next 1-2 months following receipt of referral. Inappropriate referrals will be sent back to the referring physician. Your patient will be contacted within 5 business days following receipt of referral.