Alberta Health Services

Colorectal Cancer Screening Referral

☐ Coaldale Clinic - **Fax to (403) 345-2698**
Phone (403) 345-7009

☐ North Zone - **Fax to (780) 670-3609**
Phone (780) 882-2406

☐ Northern Lights Regional Health Centre Ambulatory Care Booking Office - **Fax to (780) 788-1328**
Phone (780) 793-8390

Last Name	First Name
Address	Date of Birth
City	ULI
Postal Code	Gender
Phone Home	Other

Eligibility Criteria for Consultation and Screening

1. Must be **asymptomatic.**
2. If **patient is symptomatic** and has an indication for a diagnostic colonoscopy *(e.g. anemia, rectal bleeding)* they should **be referred directly to an endoscopy physician.**
3. Patient is clinically stable and able to undergo conscious sedation.

- Referrals will be accepted and assigned a priority based on the information included on this form.
- Incomplete referrals or referrals for patients that do not meet eligibility criteria will not be accepted and returned to the referring physician. **Please ensure demographics are correct.**

Primary Physician	Prac ID#	Date *(yyyy-Mon-dd)*

Eligibility Criteria

- The patient has an eligible reason for referral **- check one below**

☐ Positive FIT performed in an asymptomatic individual for colon cancer screening.
Must be age 50-74 **(append results).**

☐ Personal history of colorectal cancer (CRC) or adenomatous polyps **(append results).**

☐ Family history of CRC or high risk* adenomotous polyps in one or more first degree relatives

►1st degree relative diagnosed with CRC or high risk* adenomatous polyps:
☐ Younger than age 60 ☐ Older than age 60

►2nd degree relatives with CRC or CRP, must be age 40–74 positive FIT **(append results)**

*1) * High risk adenomotous polyps include: 3-10 adenomas, one adenoma greater than or equal to 10mm, any adenoma with villous features, high grade dysplasia or intramucosal carcinoma*

2) Patients with one second or one third degree relative with CRC or a high risk adenomotous polyp are considered average risk.

3) Screening colonoscopies will not be denied to average risk patients upon request.

☐ Polyp on sigmoidoscopy or suspected polyp on CT colonography or barium enema **(append results).**

☐ Other, e.g. Firefighter age 40 or over, *(please specify)*_____

Previous Colonoscopy

☐ No ☐ Yes ► Approximate Date *(yyyy-Mon-dd)* _____ *(attach a copy of colonoscopy/pathology reports)*

Body Mass Index	Patient Health History
Height _____ Weight _____ BMI _____	Does this patient have any significant comorbidities as listed on page 2? ☐ No ☐ Yes ► please complete page 2 ► *Please attach current medication and/or allergy list* ► *Please ensure most recent bloodwork (CBCs) is completed with referral*

Additional Requirements ***(wheelchair bound, limited mobility, guardianship, etc.)***

Specify:	☐ Interpreter needed ► Specify primary language

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Cardiac History ***(check all that apply)***

- ☐ Acute coronary syndrome *(must be greater than 12 months)*
- ☐ Angina *(must be asymptomatic in past 6 months)*
- ☐ Atrial fibrillation
- ☐ Arrhythmia
- ☐ CABG and/or coronary angioplasty and/or stent *(must be greater than 6 months post)*
- ☐ Cerebrovascular event *(must be greater than 12 months and no significant deficits)*
- ☐ Pacemaker *(must be greater than 3 months)*
- ☐ Antithrombotics ► Specify type _____
  - ☐ also taking Aspirin

Respiratory History ***(check all that apply)***

- ☐ Asthma or COPD - mild to moderate, well controlled on inhalers and/or low dose steroids
- ☐ Home O_2
- ☐ Sleep Apnea
- ☐ CPAP

Medical History ***(check all that apply)***

- ☐ Diabetes Mellitus
  - ☐ On oral hypoglycemics and/or ☐ insulin *(referring physician to manage dosing for colonoscopy)*
- ☐ Kidney disease *(glomerular filtration rate (GFR) must be greater than 45 or creatinine less than 150)*
  - ☐ Dialysis
- ☐ Chronic viral hepatitis *(without advanced cirrhosis)*
- ☐ Human immunodeficiency virus *(HIV)*
- ☐ Coagulopathy *(von Willebrand, hemophilia)*
- ☐ Seizure disorder - well controlled *(no or little seizure activity within 6 months)*
- ☐ Anatomical or structural abnormalities of neck or face

☐ Any other medical problem potentially limiting the safety of the scope and/or safety of the bowel preparation *(specify):*

Surgical History

☐ Surgery *(specify):*

Personal Symptoms ***(check all that apply)***

- ☐ Rectal Bleeding *(specify how often)* _____
- ☐ Change in bowel habits
  - ☐ acute ☐ chronic *(specify)* _____
- ☐ Abdominal Pain
  - ☐ acute ☐ chronic *(specify)* _____
- ☐ Other *(specify)* _____

Additional Comments

Referring Physician Signature	**Date** ***(yyyy-Mon-dd)***