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

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.**

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<tr>
<th>Primary Physician</th>
<th>Prac ID#</th>
<th>Date (yyyy-Mon-dd)</th>
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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* adenomatous 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 adenomatous 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

<table>
<thead>
<tr>
<th>Height</th>
<th>Weight</th>
<th>BMI</th>
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Patient Health History

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
# Cancer Screening Referral

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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 O₂
- [ ] 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

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<thead>
<tr>
<th>Referring Physician Signature</th>
<th>Date (yyyy-Mon-dd)</th>
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