Alberta Health Services

Screening-Related Colonoscopy Referral

Medicine Hat Regional Hospital

Fax: 403-528-5644 Phone: 403-529-8016

Patient label placed here *(if applicable)* or if labels are not used, minimum information below is required	
Last Name	First Name
Birthdate *(yyyy-Mon-dd)*	
Gender	PHN #
Phone Number	

- Referrals will be triaged and assigned a priority based on the information included in this form. Highest priority will be given to those with an abnormal Fecal Immunochemical Test (FIT).
- Incomplete referrals, referrals for patients that do not meet current screening guidelines, and referrals that do not meet eligibility criteria will not be accepted and will be returned to the referring physician.
- **Mandatory Sections*:** Eligibility Criteria, Patient Health History, and Body Mass Index. Please ensure these sections are complete prior to submitting referral form.

Referring Physician Name	Fax	Signature	Date *(yyyy-Mon-dd)*
PRACID #		Affiliated PCN	

Eligibility Criteria*

- Age 74 years or younger with valid AHCIP coverage
- Asymptomatic. No GI signs or symptoms requiring specialist consultation (i.e. rectal bleeding, anemia)
- The patient is clinically stable and able to undergo conscious sedation
- The patient has an eligible reason for referral **- check <u>one</u> below**

☐ Positive fecal occult blood test (FIT or guaiac) performed in an asymptomatic individual for colon cancer screening. Must be age 50-74; patients outside age range will be reviewed on a case by case basis **(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: (Please indicate what family member and age diagnosed)

☐ Younger than age 60 ☐ Older than age 60 ☐ Unsure of age _____

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

☐ Other *(specify)* _____

Patient Health History*	**Body Mass Index:***
Does this patient have any significant comorbidities as listed on page 2: ☐ Yes ☐ No (If yes, please complete page 2) ►*Please attach current health history summary, medications and allergy list* ►*Please ensure most recent bloodwork (CBC & Creatinine/GFR) is completed with referral form*	

Additional Requirements *(i.e. wheelchair bound, limited mobility, etc.)* Specify:	☐ Interpreter needed ► Specify primary Language

†Note: 1) High risk adenomatous polyps include: 3-10 adenomas, one adenoma >/= 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 adenomatous polyp are considered average risk.

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Previous colonoscopy

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

Cardiac History

☐ 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

☐ Asthma or COPD - Mild to moderate - well controlled on inhalers and/or low dose steroids
☐ Sleep Apnea with or without CPAP *(Note: not all facilities accept patients with BMI greater than 35 and on CPAP)*

Medical History

☐ 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)*
☐ 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. Please specify _____

Surgical History

☐ Surgery within 1 year, specify _____