

PRESS FIRMLY TO ENSURE LEGIBILITY
FAX TOP COPY TO COLON SCREENING PROGRAM: 1 (604) 297-9340

REFERRAL DATE (DD-MMM-YYYY)	COMPLETED DATE (DD-MMM-YYYY)	PATIENT NAME LAST	PATIENT NAME FIRST	SEX (F/M/X/U)
HEALTH AUTHORITY SERVICE CENTRE	AMENDED DATE (DD-MMM-YYYY)	PHN	DATE OF BIRTH (DD-MMM-YYYY)	
		PRIMARY PROVIDER (MSC)	PRIMARY PROVIDER LAST, FIRST	

ONLY ONE SECTION MUST BE COMPLETED BELOW

SECTION A: TRANSFER REQUEST (Within BC only) Complete only if referral requires a transfer to another service centre.

Transfer Request To: _____
(Name of Hospital or City)

Transfer Request Reason:

Medical Reason Patient Preference Patient Address Related

Other (Please specify): _____

SECTION B: PATIENT NOT PROCEEDING Complete only if patient is not proceeding for further follow up at your service centre.

Letter sent to PCP to inform patient not proceeding

<input type="checkbox"/> Patient not due for screening/surveillance/follow up <input type="checkbox"/> Patient declined/deferred <input type="checkbox"/> Other: _____ <input type="checkbox"/> Patient personal history does not meet colonoscopy eligibility <input type="checkbox"/> Patient family history does not meet colonoscopy eligibility <input type="checkbox"/> Patient is symptomatic, provider to refer to specialist <input type="checkbox"/> Patient is medically unfit for follow up as determined by colonoscopist <input type="checkbox"/> Patient was already referred to a specialist for colonoscopy outside of the program <input type="checkbox"/> Genetic mutation predisposing to colon cancer (e.g. Lynch Syndrome)		<p>If recall is expected, indicate recall type and future date:</p> <p>Recall for: <input type="checkbox"/> FIT <input type="checkbox"/> Colonoscopy</p> <p>Specify Future Date (MMYYYY): _____</p> <input type="checkbox"/> Patient was not able to be contacted <input type="checkbox"/> Patient moved out of province <input type="checkbox"/> Patient has colorectal cancer history <input type="checkbox"/> Patient has Crohn's or ulcerative colitis <input type="checkbox"/> Patient is deceased
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SECTION C: PATIENT IS BOOKED FOR COLONOSCOPY

Complete only when a previous Referral Update Form was sent indicating that the patient was not proceeding.

COMPLETED BY _____ SIGNATURE _____

Comments (Not captured by program): _____

