HURON PERTH HEALTHCARE ALLIANCE

Clinton Public Hospital
St. Marys Memorial Hospital
Seaforth Community Hospital
Stratford General Hospital

POSITIVE FIT
Referral Form for Colonoscopy
FAX: 519-273-3208

(PLEASE ATTACH PATIENT PROFILE OF PAST MEDICAL/SURGICAL HISTORY, MEDICATIONS, ALLERGIES)

STRATFORD SURGICAL ASSOCIATES

Legal Name: Other Name: **Birth date:** ☐ Male ☐ Female	**Phone #:** **Address:**
Health Card # and Version Code	**Date of Referral**
Referring Physician (Print)	**Referring Physician (Signature)**
Date of FIT test:	

Previous Colonoscopy Information

Date performed: _____ Endoscopist: _____

Facility: ☐ SGH
☐ Other (name):_____

Findings:
☐ Normal
☐ Adenomatous polyps
☐ >3 or >10mm in size or villous pathology

PLEASE INCLUDE COLONOSCOPY NOTES AND PATHOLOGY REPORTS WHERE AVAILABLE WITH THIS REFERRAL

All Patients must be Asymptomatic. Please refer any symptomatic patients DIRECTLY to General Surgeon of Choice.
Any other indication for colonoscopy (average risk screening, positive family history, surveillance colonoscopy, previous polyps, previous CRC) should be referred DIRECTLY to General Surgeon of Choice.

Remarks: (if preferred site for consultation, please indicate here)

☐ Stratford ☐ Clinton ☐ St. Marys ☐ Exeter ☐ Wingham ☐ Listowel