Alberta Health Services

Colon Cancer Screening Referral

- This referral is for the Forzani & Macphail Colon Cancer Screening Centre
- Referrals will be triaged and assigned a priority and recommended screening test based on the information included in this form. Highest priority will be given to those with a positive 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
- Submit referral by **fax** 403.944.3838 or for inquiries **call** 403.944.3800

Important - The referring physician must inform the CCSC of any changes in the patient that could affect priority or eligibility

Eligibility Criteria

1. Age less than or equal to 74 years with valid Alberta Health Care coverage and eligible reason for referral (see below)
2. Asymptomatic. No GI signs or symptoms requiring specialist consultation (i.e. new rectal bleeding, anemia, GI symptoms)
3. No medical conditions that would increase the risk of sedation or colonoscopy. Not on Coumadin

Patient Information

Last Name	First Name	Gender ☐ Male ☐ Female ☐ Non-binary/Prefer not to disclose (X)
Date of Birth *(dd-Mon-yyyy)*	Personal Health Number	

Contact Number	Alternate Number	Address

City	Province	Postal Code	Translation Required ☐ No ☐ Yes, language required _____

Reasons for Referral

- ☐ Positive FIT performed in an asymptomatic individual for colon cancer screening (append results) Indicate family history below
- ☐ Personal history of colon cancer or adenomatous polyps - Indicate year of diagnosis _____
- ☐ Family history of colon cancer or adenomatous polyps- Indicate family history below
- ☐ Average Risk Screening: 50-74 years, asymptomatic, no personal or family history of polyps or colon cancer *(Wait time greater than 24 months- Fecal Immunochemical Test (FIT) recommended for average risk screening)*

Family History

Relative	Cancer or Adenoma	Age at diagnosis

Has this patient had a previous colonoscopy?

- ☐ No
- ☐ Yes, provide copy of the Colonoscopy and Pathology results

Date *(dd-Mon-yyyy)* _____ Name of Endoscopist _____

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