BC CANCER COLON SCREENING
Provincial Health Services Authority

Colon Screening Program: **Colonoscopy Referral Form**

STEP 1 Complete Provider and Patient Information

PHN NUMBER	**OTHER HEALTH NUMBER (E.G. REFUGEE, MILITARY)**	**ORDERING PROVIDER (NAME, ADDRESS, MSC PRACTITIONER #)**
PATIENT LAST NAME	**PATIENT FIRST NAME**	
DATE OF BIRTH (YYYYMMDD)	**SEX** ☐ F ☐ M ☐ X	**MSC**
PATIENT ADDRESS	**CITY/TOWN** **PROVINCE**	**PRIMARY CARE PROVIDER, IF DIFFERENT FROM ORDERING (NAME, MSC PRACTITIONER #)**
PATIENT TELEPHONE NUMBER (CELL NUMBER PREFERRED)	**POSTAL CODE**	**MSC**
LANGUAGE PREFERRED	**REFERRAL DATE** (YYYYMMDD)	**PROVIDER SIGNATURE**

STEP 2 Confirm Eligibility and Select at Least One Indication for Colonoscopy

Patients are **excluded** from the Colon Screening Program (screening colonoscopy and fecal immunochemical test [FIT]) if they:

- Are up to date with colon screening or have had a normal FIT result in the past two years (average risk individuals).
- Have a personal history of colorectal cancer, ulcerative colitis or Crohn's disease. These individuals should continue to obtain care through their specialist or health care provider.
- Currently have symptoms, e.g. rectal bleeding, persistent change in bowel habits, abdominal pain, unexplained weight loss or iron deficiency anemia. These patients should be referred to a specialist, no FIT required.
- Are on a definite surveillance plan through a specialist.

Screening Colonoscopy (Do not order FIT for these patients)

Recommended for individuals up to age 74 (inclusive), at higher than average risk.

- For those with a family history of colon cancer the first screening colonoscopy should be done at age 40 or 10 years younger than the age of diagnosis of the youngest affected FDR - whichever is earliest.

- ○ One first degree relative with colorectal cancer diagnosed under the age of 60; or,
- ○ Two or more first degree relatives with colorectal cancer diagnosed at any age; or,
- ○ A personal history of adenoma(s), sessile serrated lesion(s) or traditional serrated adenoma(s)

○ DUE NOW
○ DUE: _____ (YYYYMM)

Colonoscopy for Abnormal FIT (for individuals ages 50-74 only)

○ Abnormal FIT Result date: (YYYYMMDD) _____

For COLONOSCOPISTS ONLY (Complete Colonoscopy Reporting Form [CRF] at time of colonoscopy)

○ Register patient into Colon Screening Program. Patient booked/had colonoscopy (No pre-colonoscopy assessment required).

Planned Procedure Date: _____ (YYYYMMDD) Endoscopy Unit: _____

Select at least one indication:

○ Abnormal FIT ○ Personal Hx of Adenomas ○ FHx (1st Degree relative < 60 y.o.) ○ FHx (2+ 1st Degree relatives)

STEP 3 Fax Form to BC Cancer Colon Screening: **1-604-297-9340**

Patients will be contacted by their Health Authority to arrange an assessment for colonoscopy when required.