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 (DD-MMM-YYYY)	**SEX** ☐ F ☐ M ☐ X ☐ U	**MSC**
PATIENT ADDRESS	**CITY/TOWN** **PROVINCE**	**PRIMARY CARE PROVIDER, IF DIFFERENT FROM ORDERING (NAME, ADDRESS, MSC PRACTITIONER #)**
PATIENT HOME NUMBER / **PATIENT CELL NUMBER** / **POSTAL CODE**		**MSC**
LANGUAGE PREFERRED	**REFERRAL DATE** (DD-MMM-YYYY)	**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:

- Currently have symptoms (e.g. rectal bleeding, persistent change in bowel habits, abdominal pain, or unexplained weight loss). These individuals should be referred to a specialist, no FIT required.
- 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.
- Are on a definite surveillance plan through a specialist.
- Documented genetic mutation predisposing to colon cancer (e.g. Lynch Syndrome).

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: _____ (MMM-YYYY)

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

- ○ Abnormal FIT Result date: (DD-MMM-YYYY) _____

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: (DD-MMM-YYYY) _____ 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.