

# Timmins and District Hospital



**NURSE PERFORMED  
FLEXIBLE SIGMOIDOSCOPY  
ELIGIBILITY, ASSESSMENT  
AND REFERRAL FORM**

Date: (yyyy/mm/dd)		<b>Referring Physician Information</b>					
<b>Allergies:</b>							
<input checked="" type="checkbox"/>	<b>Eligibility Criteria (all must be <input checked="" type="checkbox"/> to be eligible)</b>						
	Age 50-74						
	Patient is <b>not</b> on Anticoagulant Therapy						
<b>Negative</b> FOBT within 2 years – test date (yyyy/mm/dd) _____ OR if no test within 2 years, FOBT kit provided? <input type="checkbox"/> yes OR <input type="checkbox"/> no – Reason: _____							
<b>No personal history</b> of Inflammatory bowel disease (Crohn's, Colitis)							
<b>No family history</b> of Colorectal Cancer (First degree relative, Parent, sibling, child)							
<b>No history</b> of bowel symptoms (i.e. rectal bleeding; sudden change in bowel habits; new onset constipation)							
<b>No previous polyps</b> or history of colorectal cancer or colonoscopy within 10 years							
<b>Relevant History</b>		<b>Yes</b>	<b>No</b>	<b>Relevant History</b>		<b>Yes</b>	<b>No</b>
History of heart disease				Lung Disease (COPD/Emphysema)			
Pacemaker/Implantable Cardiac Defibrillator				Cancer			
Bleeding Disorders				Previous Abdominal Surgery			
Diabetes							
<b>Medication History:</b> Patient is on Anticoagulant Therapy, <input type="checkbox"/> Coumadin , <input type="checkbox"/> Plavix, <input type="checkbox"/> Dabigatran (Pradax), <input type="checkbox"/> Rivaroxaban							
<b>FOR NURSING USE ONLY</b>							
Procedural Consent obtained							
Patient Appointment and education pamphlet: <input type="checkbox"/> Provided <input type="checkbox"/> Will be mailed with specific instructions							
Refer patient for colonoscopy for abnormal pathology results from nurse performed flexible sigmoidoscopy.							

Completed by: \_\_\_\_\_  
RN Printed Name

\_\_\_\_\_  
RN Signature

Family Physician Signature: \_\_\_\_\_

**FAX (705) 267-6325**