Fecal Immunochemical Test (FIT) Requisition – For Mailed Colorectal Cancer Screening

Form Completion Fee Code
Q150A

In-Common Laboratories
Lab Solutions Made Easy

Eligibility Criteria:

- Age 45 to 74[1]
- Asymptomatic
- Due for screening (no FIT in the last two years, and no flexible sigmoidoscopy or colonoscopy in the last 10 years)
- Ontario Health Insurance Plan (OHIP) coverage

[1] ColonCancerCheck does not recommend routine screening for people over 74 years. Decisions to screen those between the ages of 75 to 85 years should include an assessment of risks and benefits, and take into consideration health, life expectancy, and prior screening history. Requisitions will be accepted for people up to 85 years of age.

Note:
- Do not use for the workup of patients with GI symptoms, overt GI bleeding and/or anemia
- Do not use for patients with a personal history of colorectal cancer, Crohn's disease involving the colon or ulcerative colitis
- ColonCancerCheck's colorectal cancer screening recommendations can be found at ontariohealth.ca/CCC-recommendations

REPLACEMENT KIT NEEDED (i.e., prior FIT was lost, damaged, or not received by patient).
Check this box only if this is a request for a replacement FIT kit. Call In-Common Laboratories for questions: 1-833-FIT-POOP (1-833-348-7667)

All sections on this form must be accurate and complete. Missing information may result in the requisition being rejected. **Fax the requisition to 1-833-520-1544**

1. Requester Information

Requester Type (check one): Physician Mobile Coach Nurse Practitioner Health811	Mobile Coach ID:		CPSO or CNO Number:
Last Name:	Middle Name (optional):		First Name:
Address (Street No. and Name):	Unit/Suite/PO Box:		Phone:
City:	Province:	Postal Code:	Fax:

Copy to: Physician/Nurse Practitioner/Nurse in Charge at Nursing Station or Health Centre. If same as Requester, do not complete this section.

Last Name:	Middle Name (optional):	First Name:	CPSO or CNO Number (if available):
Address (Street No. and Name):		Unit/Suite/PO Box:	Phone:
City:	Province: Ontario	Postal Code:	Fax:

2. Patient Information (Ontario Health – Cancer Care Ontario result letters and other correspondence will be sent to the Patient Address)

Last Name (on OHIP card):	Middle Name (on OHIP card, optional):		First Name (on OHIP card):	
Date of Birth (on OHIP card): yyyy/mm/dd	OHIP Number:		Sex (on OHIP card): Male Female Other	
Patient Address (Street No. and Name):	Unit/Suite/PO Box:		Primary Phone Number:	Ext. (optional):
City:	Province:	Postal Code:	Type: Work Home Cell	

3. FIT Kit Mailing Address (for patients who prefer to have their kit mailed to a different address within Ontario)

FIT Kit Mailing Address (Street No. and Name):	Unit/Suite/PO Box:	Facility Name (if applicable):
City:	Province: Ontario	Postal Code:

4. Requester Verification (must include an updated date for replacement requests)

Requester Signature:	Date: yyyy/mm/dd

Need this information in an accessible format ou en Français?
1-877-280-8538, TTY 1-800-855-0511, info@ontariohealth.ca

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Ce document est disponible en anglais seulement en raison de son public cible limité. Une version en français peut être fournie sur demande à titre de référence uniquement. Pour toute question ou de l'aide concernant ce document, veuillez contacter info@ontariohealth.ca.