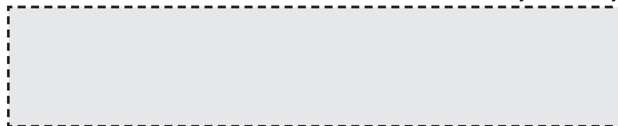
Laboratory Use Only



FIT TESTING REQUISITION

Please fax to ColonCheck Yukon for tracking at 867-667-5718 and give the original copy to patient.

LAST NAME:	FIRST NAME:		Date Collection Kit Given to Patient: YYYY/MM/DD *(Clinic or Health Centre)*
DATE OF BIRTH: YYYY/MM/DD	HEALTH CARE #: (Prov)	☐ M ☐ F	*Specimen Collection Date: YYYY/MM/DD *(Health Centre/Clinic/WGH Lab to verify)*
SUBMITTING DOCTOR:	CLINIC/HEALTH CENTRE:		Received Date: YYYY/MM/DD *(Health Centre)*
COPY REPORT TO: ***ColonCheck Yukon*** COPY REPORT TO: ______________________			Date Received: YYYY/MM/DD *(WGH Lab)*

Previous colorectal cancer screening?

☐ New to Screening ☐ Previous FIT/gFOBT ☐ Colonoscopy ☐ Other ______________ *(specify)* Approximate date ______________ YYYY/MM/DD

Information contained in this form is collected, used and disclosed in accordance with *Yukon's Health Information Privacy and Management Act* and other applicable laws. Questions regarding *ColonCheck Yukon* and their information practices should be directed to the Manager, *ColonCheck Yukon* at 867-667-5497. A written statement of Health and Social Services information practices can viewed at www.hss.gov.yk.ca/healthprivacy.php or by contacting the department's Privacy Officer at healthprivacy@gov.yk.ca

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