FIT TESTING REQUISITION

Laboratory use only

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: **R.COLON** Copy report to: ______				Date received YYYY/MM/DD *(WGH lab)*

Previous colorectal cancer screening?

☐ New to screening ☐ Previous FIT/gFOBT ☐ Colonoscopy

☐ Other (specify) ______ Approx. 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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