Thames Valley
Family Health Team

Medical Directive

Ordering Fecal Immunochemical Test (FIT)	**Assigned Number: 031**
Activation Date: August 1, 2024	**Review due: December 2027**

Approval Signature & Date

Medical Director: _____ Date Reviewed: Aug 11, 2026

Executive Director, Clinical Services: _____ Date Reviewed: Aug 11, 2026

Order and/or Delegated Procedure:	**Appendix Attached:** ☐ **Yes** ☒ **No**

Release of requisition for Fecal Immunochemical Testing (FIT) for colorectal cancer screening.

Recipient Patients:	**Appendix Attached:** ☐ **Yes** ☒ **No**

All active patients (attached or unattached) served by Thames Valley Family Health Team nurse practitioners, as identified on the Authorizer Approval Form.

Authorized Implementers:	**Appendix Attached:** ☐ **Yes** ☒ **No**

Thames Valley Family Health Team Registered Nurses (RN), Registered Practical Nurses (RPN), and Patient Care Assistants (PCA)

The implementer must complete educational requirements for this medical directive, including review of the education package and medical directive, and successful completion of any quizzes. If additional orientation or shadowing is needed, the implementer must make arrangements for this with their clinical supervisor. Once all the above has been completed, they are required to sign the Implementer Performance Readiness Form electronically, via Citation Canada, indicating they have the knowledge, skill, and judgment to safely enact the medical directive.

Indications:	**Appendix Attached:** ☐ **Yes** ☒ **No**
Patient meets current Cancer Care Ontario's Colon Cancer Check average-risk eligibility criteria.	
Contraindications:	**Appendix Attached:** ☐ **Yes** ☒ **No**
Patient does not meet Cancer Care Ontario's Colon Cancer Check average-risk eligibility criteria and is suspected to be at increased risk– *refer these patients to the Nurse Practitioner for assessment. Increased risk includes: • Patients with one or more first-degree relative(s) with colorectal cancer • Patients with symptoms including rectal bleeding or anemia	
Consent:	**Appendix Attached:** ☐ **Yes** ☒ **No**
Informed verbal consent is obtained from the patient/substitute decision maker, per TVFHT: Informed Consent of Patient Healthcare Procedure, prior to the implementation of care.	
Guidelines for Implementing the Order/ Procedure:	**Appendix Attached:** ☐ **Yes** ☒ **No**
1. Confirm patient meets criteria for FIT according to Cancer Care Ontario recommendations. 2. Explain the purpose and process of the test to the patient. 3. Confirm patient's preferred mailing address, prepare FIT requisition, and fax to LifeLabs.	
Documentation and Communication:	**Appendix Attached:** ☐ **Yes** ☒ **No**
• The implementer will follow the documentation standards set by their governing college. • In the patient's medical record, documentation must be completed on the TVFHT documentation template provided for this directive. • Information regarding implementation of the directive and the patient's response will be documented in the patient's medical record, in accordance with standard documentation practice. • Requisitions released must include the name and number of the directive, name of authorizer, name and signature of implementer.	

Review and Quality Monitoring Guidelines:	**Appendix Attached:** ☐ **Yes** ☒ **No**

The directive remains in effect until amended. It will be reviewed biennially or under the following circumstances:

1. The Medical Director identifies a need for change
2. Issues arise related to the directive's use—the team must promptly communicate these concerns to their clinical supervisor, Medical Directives Coordinator, or Clinical Director
3. New information becomes available between scheduled reviews, particularly if it affects outcomes

The Medical Directives Committee will then review the concerns in consultation with at least one implementer and the Medical Director, as needed, before making necessary changes.

Approving Authorizer(s):	**Appendix Attached:** ☐ **Yes** ☒ **No**

Authorizer Approval Form signed in Citation Canada.