Colorectal Diagnostic Assessment Program
PATIENT REFERRAL FORM

Please fax referral form and other documents to:
(905) 681-4830

Patient Information (or affix sticker)

Name: ______________________
Address: ______________________
City: ______________________
Postal Code: ______________________
Home Phone: ______________________
Alt. Phone: ______________________
DOB (D/M/Y): ____________ Gender: ____________
HCN: ______________________
Family Physician: ______________________

All patients referred to the Colorectal Diagnostic Assessment Program (DAP) may receive CT, MRI, and laboratory investigations.
The Colorectal DAP will provide patients with timely access to an interdisciplinary team including surgeon, pathologist, radiologist, registered nurse.

Referring Provider Information

Name:	Billing Number:
Phone:	Fax:
Date of Referral (D/M/Y):	Signature:

Requested Surgeon (This surgeon will communicate diagnosis and manage subsequent care)

❑ Next available ❑ Specific surgeon requested (please indicate):

(Note: selecting a specific surgeon may result in a less expedited initial consultation, depending on surgeon availability)

Indication for Referral

❑ Biopsy proven colorectal cancer
❑ Colonic mass/polyp with high suspicion of malignant disease or not amenable to endoscopic resection
❑ High risk colonic polyp (e.g. piecemeal resection with high grade dysplasia pathology)
❑ Abnormal imaging suggesting colorectal cancer (e.g. CT colonography)

Patient has been informed of referral to Colorectal DAP?	**Patient aware of diagnosis?**	
❑ Yes (Patient must be aware of this referral)	❑ Yes	❑ No

Endoscopy History

Procedure Performed	❑ Colonoscopy	❑ Flexible Sigmoidoscopy	❑ None
Endoscopy Facility			
Location of Tumour	❑ Cecum / Right Colon	❑ Transverse Colon	❑ Left Colon / Sigmoid
	❑ Rectum (< 15 cm from anus)	❑ Other / Comment ______________________	

Staging Investigations Initiated (Note: None necessary prior to referral)

❑ None (All staging and work-up to be initiated by DAP Navigator and/or JBH Physician's office)
❑ Laboratory Investigations (including CBC, Creatinine, CEA)
❑ CT Scan Chest/Abdomen/Pelvis (Facility: ______________________)
❑ MRI Pelvis (Facility: ______________________)

Supporting Documentation

As available, please attach imaging reports, endoscopy reports, laboratory results, pathology reports, consultation notes, cumulative patient profile

Thank you for the referral. The DAP Navigator will contact your office to confirm receipt of referral.
Your patient will be contacted directly with relevant appointment dates and times.
If you have not received confirmation within 72-96 hours, please contact (905) 632-3737 ext. 1339