



### Colorectal Diagnostic Assessment Program PATIENT REFERRAL FORM

Please fax referral form and other documents to:  
**(905) 681-4961**

#### 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?

<input type="checkbox"/> Yes (Patient must be aware of this referral)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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#### Endoscopy History

Procedure Performed	<input type="checkbox"/> Colonoscopy	<input type="checkbox"/> Flexible Sigmoidoscopy	<input type="checkbox"/> None
Endoscopy Facility			
Location of Tumour	<input type="checkbox"/> Cecum / Right Colon	<input type="checkbox"/> Transverse Colon	<input type="checkbox"/> Left Colon / Sigmoid
	<input type="checkbox"/> Rectum (< 15 cm from anus)	<input type="checkbox"/> 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**