

Colorectal Diagnostic Assessment Program

PLEASE COMPLETE AND FAX REFERRAL FORM TO 416-756-6832

Patient Information		
Last Name:	First Name:	DOB:
Health Card #:	Version:	Gender:
Address:	City:	Postal Code:
	Preferred Phone #:	

Reason for Referral
<input type="checkbox"/> Diagnosed Colorectal Cancer <ul style="list-style-type: none"> • Abnormal Ultrasound/CT imaging results • Endoscopic/biopsy findings proven colorectal cancer
<input type="checkbox"/> Symptoms highly suspicious for colorectal cancer <ul style="list-style-type: none"> • Palpable rectal mass • Unexplained iron-deficiency anemia • Positive fecal occult blood test • Suspicious rectal bleeding/change in bowel function and/or weight loss
Medical History and other pertinent information (e.g. allergies, medications, etc.):

Diagnostic Investigations - please attach ALL reports with referral if available. If not, we will arrange.	
Endoscopy performed:	<input type="checkbox"/> Colonoscopy Date completed: _____ <input type="checkbox"/> Flex Sigmoidoscopy Date completed: _____ <input type="checkbox"/> Tattoo of lesion
Location of tumour:	<input type="checkbox"/> Right Colon <input type="checkbox"/> Transverse Colon <input type="checkbox"/> Left or Sigmoid Colon <input type="checkbox"/> Rectum (≤ 15 cm from anus)
Other tests:	<input type="checkbox"/> MRI Scan Date completed: _____
	<input type="checkbox"/> CT Scan Date completed: _____
	<input type="checkbox"/> Ultrasound Date completed: _____
	<input type="checkbox"/> Bloodwork Date completed: _____

Referral Request		
<input type="checkbox"/> Earliest appointment OR		
<input type="checkbox"/> Dr. Peter Stotland	<input type="checkbox"/> Dr. Stan Feinberg	<input type="checkbox"/> Dr. Usmaan Hameed
<input type="checkbox"/> Dr. Lloyd Smith	<input type="checkbox"/> Dr. Donna McRitchie	<input type="checkbox"/> Dr. Nancy Down
<input type="checkbox"/> Dr. Simon lu	<input type="checkbox"/> Dr. Brian Pinchuk	<input type="checkbox"/> Dr. Yasser Botros
<input type="checkbox"/> Dr. David Smith		

Physician Information	
Referring Physician:	Family Physician:
Billing #:	Billing #:
Phone #:	Phone #:
Fax #:	Fax #:
Referral Date:	

NOTE: Your patient **MUST** be aware of this referral and will be contacted by our patient navigator. The patient navigator can be reached at **416-756-6000 ext. 4409, 416-575-6276** or colorectal.navigators@nygh.on.ca