

Colorectal Diagnostic Assessment Program

| PLEASE COMPLETE AND FAX REFERRAL FORM TO (416) 736 - 6632 | | | | | |
|---|--------------------------------------|---|-------------------|-------------------|--|
| Patient Information | | | | | |
| Last Name: | | First Name: | | DOB: | |
| Health Card #: | | Version: | | Gender: | |
| Address: | | City: | | Postal Code: | |
| | | Preferred Phone #: | | | |
| | | | | | |
| Reason for Referral | | | | | |
| □ Diagnosed Colorectal Cancer | | | | | |
| Abnormal Ultrasound/CT/MRI imaging results Findescenic/hieray/findings proves calculated appears | | | | | |
| Endoscopic/biopsy findings proven colorectal cancer Company to the color of t | | | | | |
| □ Symptoms highly suspicious for colorectal cancer • Palpable rectal mass | | | | | |
| Unexplained iron-deficiency anemia | | | | | |
| Positive fecal immunochemical test | | | | | |
| Suspicious rectal bleeding | | | | | |
| Change in bowel function | | | | | |
| Unexplained weight loss Madical History and other participations (a participation and institute and other participation). | | | | | |
| Medical History and other pertinent information (e.g. allergies, medications, etc.): | | | | | |
| | | | | | |
| Patient information of Diagnosis?YesNo | | | | | |
| Diagnostic Investigations - please attach ALL reports with referral if available. If not, we will arrange. | | | | | |
| Endoscopy | □ Colonoscopy | Date completed: | | | |
| performed: | ☐ Flex Sigmoidoscopy Date completed: | | | | |
| l a sation of | ☐ Tattoo of lesion | | | | |
| Location of tumour: | ☐ Right Colon☐ Left or Sigmoid Co | ☐ Transverse Colon olon ☐ Rectum (≤ 15 | cm from anus) | | |
| Other tests: | □ MRI Scan | Date completed: | | | |
| | □ CT Scan | Date completed: | | | |
| | □ Ultrasound | Date completed: | | | |
| | □ Bloodwork | Date completed: | | | |
| | | Date completed. | | | |
| Referral Request | | | | | |
| | t appointment OR | | | | |
| □ Dr. Peter Stotland | | □ Dr. Stan Feinberg | | Dr. Usmaan Hameed | |
| ☐ Dr. Nancy Down | | ☐ Dr. Trevor Wood | | Dr. Yasser Botros | |
| ☐ Dr. Dav | ☐ Dr. Brian Pinchuk | | | | |
| Dhysician Information | | | | | |
| Physician Information | | | | | |
| Referring Phys | sician: | | Family Physician: | | |
| Billing #: | | · · | Billing #: | | |
| Phone #: | | Phone #: | Phone #: | | |
| Fax #: | | Fax #: | Fax #: | | |
| Referral Date: | | | | | |