NORTH YORK GENERAL
Making a World of Difference

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
☐ Diagnosed Colorectal Cancer • Abnormal Ultrasound/CT imaging results • Endoscopic/biopsy findings proven colorectal cancer
☐ Symptoms highly suspicious for colorectal cancer • 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:	☐ Colonoscopy ☐ Flex Sigmoidoscopy ☐ Tattoo of lesion	Date completed:_____ Date completed:_____
Location of tumour:	☐ Right Colon ☐ Left or Sigmoid Colon	☐ Transverse Colon ☐ Rectum (≤ 15 cm from anus)
Other tests:	☐ MRI Scan	Date completed:
	☐ CT Scan	Date completed:
	☐ Ultrasound	Date completed:
	☐ Bloodwork	Date completed:

Referral Request		
☐ Earliest appointment OR		
☐ Dr. Peter Stotland	☐ Dr. Stan Feinberg	☐ Dr. Usmaan Hameed
☐ Dr. Lloyd Smith	☐ Dr. Donna McRitchie	☐ Dr. Nancy Down
☐ Dr. Simon Iu	☐ Dr. Brian Pinchuk	☐ Dr. Yasser Botros
☐ 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.navigator@nygh.on.ca**