

Colorectal Cancer Diagnostic Assessment Program

Date of Referral: _____

Please note: Please ensure your patient is aware of this referral as they will be contacted by our navigator
Consider **referring early** - Staging will be expedited on behalf of our program

PATIENT INFORMATION		
Last Name:	First Name:	DOB:
OHIP :		Gender:
Address:	City:	Postal Code:
	Preferred Phone #:	

REFERRING PHYSICIAN	
Name:	Billing #:
Phone :	Fax :

REASON FOR REFERRAL	
<input type="checkbox"/> New CRC <ul style="list-style-type: none"> <input type="radio"/> Early Onset (<50 years old) <input type="radio"/> Elder Onset (>70 year old) 	<input type="checkbox"/> Symptoms highly suspicious for CRC <ul style="list-style-type: none"> <input type="radio"/> Palpable rectal mass <input type="radio"/> Positive fecal immunochemical test <input type="radio"/> Suspicious rectal bleeding <input type="radio"/> Abnormal Ultrasound/CT imaging results
<input type="checkbox"/> Second Opinion	
History	
Past Medical History	

ENDOSCOPY PERFORMED – Please attach reports and pathology if available	
<input type="checkbox"/> Colonoscopy	<input type="checkbox"/> Flexible Sigmoidoscopy

TUMOUR LOCATION	
<input type="checkbox"/> Right	<input type="checkbox"/> Transverse
<input type="checkbox"/> Left or Sigmoid	<input type="checkbox"/> Rectum (<15cm from anus)

IMAGING	
CT	<input type="checkbox"/> Chest <input type="checkbox"/> Abdo / Pelvis
MRI	<input type="checkbox"/> Rectum <input type="checkbox"/> Liver

Our Surgeons – <input type="checkbox"/> Next available or specific to:	
<input type="checkbox"/> Dr. Daniel Abramowitz	<input type="checkbox"/> Dr. Usmaan Hameed
<input type="checkbox"/> Dr. Stan Feinberg	<input type="checkbox"/> Dr. Peter Stotland

Program contact:
Fax (416) 756-683-6832
E-referral nygh.on.ca/colorectal/referral
Email gi.navigators@nygh.on.ca
Ph (416) 756-6000 x 4409 or (416) 575-6276