MOUNT SINAI HOSPITAL
Bright Minds. Big Hearts. The Best Medicine.

COLORECTAL CANCER DAP REFERRAL FORM

PLEASE COMPLETE AND FAX REFERRAL FORM TO (416)586-4853

REASON FOR REFERRAL

☐ Diagnosed Colorectal Cancer (*Full consult and plan to be provided within 1-2 weeks)*

- Palpable rectal mass
- Abnormal US/CT imaging suspicious for colorectal cancer
- Endoscopic findings suspicious for colorectal cancer/biopsy proven colorectal cancer

PLEASE ATTACH ALL REPORTS AND PROVIDE PATIENT WITH CD OF IMAGING STUDIES.
Your office and the patient will be contacted within the next 48 hours (2 work days) for an appointment date.

☐ Symptoms highly suspicious for colorectal cancer (*Full consult and plan to be provided within 2-4 weeks)*

- Unexplained iron-deficiency anemia
- Positive fecal occult blood test
- Unexplained rectal bleeding (e.g. bleeding mixed with stool, combined with change in bowel habits and/or weight loss

PLEASE ATTACH ALL REPORTS.
Your office and the patient will be contacted within the next 48 hours (2 work days) for an appointment date.

REFERRING PHYSICIAN INFORMATION

Date of Referral:	
Name:	
Billing #:	
Office Phone:	Office FAX:

PATIENT INFORMATION

Name:	
DOB:	
HCN:	VC:
Home Phone:	Cell/Work Phone:
Address:	

How did you find out about the MSH Colorectal DAP Program?

☐ e-mail ☐ mail ☐ website/internet ☐ word of mouth ☐ other

If you would like to be on our contact list to receive updates about this program, please provide your email below.
