Simcoe Muskoka Regional Cancer Program

RVH Royal Victoria Regional Health Centre

A Cancer Care Ontario Partner

SUSPICION OF CANCER, THORACIC OR RECTAL DIAGNOSTIC ASSESSMENT PROGRAM (DAP) REFERRAL

SIMCOE MUSKOKA REGIONAL CANCER PROGRAM
201 GEORGIAN DRIVE, BARRIE, ONTARIO L4M 6M2
www.rvh.on.ca

Please Complete:
Patient Information, the section for the appropriate DAP & Provider Information

PATIENT INFORMATION

Surname	First Name	Gender ☐F ☐ M	D.O.B dd/mm/yy
Address	City/Province	Postal Code	Phone Number
RVH V# (if applicable)	OHIP # (with version code)	Does patient identify as Aboriginal? ☐ Yes Special assistance required: ☐ Interpreter ☐Visually impaired ☐Hearing impaired	

Patient Details/Significant Medical History:

☐ Thoracic DAP (For patient pamphlet click here)

Phone: 705-728-9090 ext 43519

CT must be ordered for all patients referred to the thoracic DAP

Referral to: ☐ Respirologist ☐ Thoracic Surgeon ☐ Either

CT: ☐ Completed & Attached ☐ Ordered If ordered, Date & Location of Upcoming CT: _____

Reason for Referral:

☐ Abnormal Imaging:
Date of Imaging: _____ Location: _____ Type: ☐ Chest X-Ray ☐ CT ☐ Other _____

☐ Concerning Symptoms: _____

Medications: ☐ Anticoagulant ☐ Antiplatelet ☐ ASA/NSAIDS ☐ Bronchodilators

☐ Suspicion of Cancer (SoC) DAP (For patient pamphlet click here)

Phone: 705-728-9090 ext 43144

Reason for cancer suspicion: _____

Clinical documents:	**Attached**	**Pending**	**If pending, date and facility**
Patient history and consult notes	☐	☐	_____
Lab	☐	☐	_____
Imaging	☐	☐	_____
Cardio/pulmonary	☐	☐	_____

☐ Rectal DAP

Phone: 705-728-9090 ext 43519

*Only colonoscopy confirmed tumors <15cm from anal verge accepted

Routine Orders (Indicate what NEEDS to be ordered)	**Attached**	**Pending**	**If pending, date and facility**
CT Chest / Abdo / Pelvis	☐	☐	_____
MRI Pelvis (if tumor <15cm by scope)	☐	☐	_____
Colorectal Lab Set & CEA (CBC, Creatinine, Electrolytes, BUN, LFT, LDH)	☐	☐	_____
CT Abdomen / Pelvis	☐	☐	_____
Oncologist Consult if Indicated by MCC	☐	☐	_____
Diagnostic information:			
Colonoscopy report	☐	☐	**Mass is _____ cm from anal verge**
Pathology sent	☐	☐	

REFERRING PROVIDER INFORMATION

Name	Phone	Fax
Address	Date	Billing #:
Family Physician: ☐Referring same as family physician		Referring Physician Signature

Please inform ALL PATIENTS of referral. SMRCP will contact patients directly with appointment details.

Fax: 705-739-5636

Version 1 Ap.17

DRAFT