



COLORECTAL DIAGNOSTIC ASSESSMENT PROGRAM - REFERRAL (Biopsy proven or high suspicion of malignant disease)

Date of Referral	Patient Details	
Date of Referral _____ (yyyy/mm/dd)	Name:	
	Health Card:	
	Date of Birth (yyyy/mm/dd):	
	Phone:	
	Address:	
Presenting Illness/Reason for Referral:		
Biopsy proven colorectal cancer Palpable rectal mass Obvious colonic mass with high suspicion of malignant disease, not amenable to resection High risk colonic polyp (peacemeal resection with high grade dysplasia pathology) Abnormal imaging, CT colonography (suggesting CRC)		
Diagnostic Investigations Completed:		
Blood work Sigmoidoscopy Colonoscopy Computed tomographic (CT) (CT) Colonography MRI Chest X-ray Pathology of colonic or rectal lesion Other		
Patient Aware of Referral?	Yes	No
Patient Aware of Potential Cancer Diagnosis?	Yes	No
Please fax us the following information:		
Completed referral form Recent blood work (CBC, ferritin (if low MCV)) Imaging reports Endoscopy procedure report Pathology result List of current medications (including ALL anticoagulants, antiplatelets, and NSAIDS) Past medical history		
Referred by: Family Physician Nurse Practitioner Surgeon Gastroenterologist		
_____	_____	_____
(please print)	Phone	Fax
Signature: _____ CPSO: _____		
Fax Number: (613) 544-3319 - DAP@kgh.kari.net Colorectal DAP Nurse Navigator Telephone: (613) 544-3400 x2653		
DAP Office Only <input type="checkbox"/> NN consult <input type="checkbox"/> Access Database		

CRC- colorectal cancer CBC - complete blood count MCV- mean corpuscular volume NSAIDS- nonsteroidal anti-inflammatory drug NN- Nurse Navigator DAP -Diagnostic Assessment Program CPSO- College of Physicians & Surgeons of Ontario