Sunnybrook
ODETTE CANCER CENTRE
A Cancer Care Ontario Partner

Colorectal Cancer Referral Form

Diagnostic Assessment Program

Phone: 416-480-5658 Fax: 416-480-7818 crc.dap@sunnybrook.ca

PATIENT IDENTIFICATION

Referral Date (YYYY/MM/DD):_____/_____/_____

PATIENT INFORMATION

Last Name: _____ First Name: _____ DOB: _____

OHIP card: _____ Preferred Phone Number: _____

PHYSICIAN INFORMATION

Referring Physician: _____ OHIP billing #: _____

Bus. Tel: _____ Fax: _____

REFERRAL FOR EXPEDITED COLONOSCOPY (for suspicion of colorectal cancer)

☐ FOBT+ ☐ FIT+ ☐ Palpable rectal mass ☐ Abnormal imaging

☐ Rectal bleeding (with absence of perianal symptoms) **AND** 1 or more of the following:

☐ Unexplained weight loss ☐ First degree family history of colorectal cancer ☐ Palpable abdominal mass

☐ Change in bowel habits ☐ Unexplained iron-deficiency anemia (Males: Hb ≤ 110 g/L, Post-menopausal females: Hb ≤ 100 g/L)

☐ Other: _____

NOTE:
Your patient will receive a colonoscopy within 2-3 weeks and you will receive a faxed report on the day of the colonoscopy.
Positive findings will receive expedited care by the multidisciplinary oncology team at Sunnybrook Health Sciences Centre.
Inappropriate referrals will be sent back to the referring physician.

REFERRAL FOR COLORECTAL CANCER (or endoscopic suspected colorectal cancer)

Endoscopy Performed: please include colonoscopy report and biopsy result if available)

☐ Colonoscopy ☐ Flexible Sigmoidoscopy

Location of Tumor

☐ Right Colon ☐ Transverse Colon ☐ Left Colon/Sigmoid

☐ Rectum (15cm or less from anus) ☐ Lesion Tattooed

MEDICAL HISTORY AND/OR OTHER PERTINENT INFORMATION

_____

_____

REFERRAL REQUEST

☐ Earliest Appointment ☐ Dr. Shady Ashamalla ☐ Dr. Darlene Fenech

Your patient will be contacted immediately following receipt of referral by our nurse navigator
FOR MORE INFORMATION OR TO USE OUR e-REFERRAL, PLEASE VISIT:

sunnybrook.ca/colorectal

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