BLUEWATER HEALTH

Cancer Care Assessment and Treatment Centre – Colorectal Referral Form

Place Patient Label Here

PHYSICIAN REFERRAL FORM

DOB (dd/mm/yyyy): ☐ M ☐ F	Referring Physician:
Address: City:	Telephone: Fax:
Postal Code:	Physician Signature:
HCN & VC:	Family Physician/ Nurse Practitioner:
Telephone 1: Telephone 2:	Patient notified of referral to DAP: ☐ Yes ☐ No Patient aware of cancer risk: ☐ Yes ☐ No Referred to Medical Oncology ☐ Yes ☐ No Patient aware of Pathology ☐ Yes ☐ No

History of presenting illness / concern: _____

_____

Pertinent Health History: ☐ Other: _____

☐ Coronary Artery Disease/CHF ☐ Liver Cirrhosis ☐ COPD on home Oxygen ☐ CVA/TIA
☐ Diabetes ☐ Anti Coagulation ☐ Kidney Dialysis ☐ Prosthetic Valve/Previous Endocarditis

COLORECTAL DIAGNOSTIC ASSESSMENT PROGRAM

☐ **FOBT+ (**Please fax report with referral) ☐ **Family History** (First degree relative with CRC)

☐ Yes ☐ No Abdominal examination performed
☐ Yes ☐ No P.R. examination performed
☐ Yes ☐ No A definite abdominal or palpable rectal (not pelvic) mass on PR examination
☐ Yes ☐ No Rectal bleeding with a change in bowel habit to looser stools and/or increased frequency of defecation – persistent for 6 weeks
☐ Yes ☐ No Iron deficiency anemia without an obvious cause (Hb < 11 g/dl in men or < 10 g/dl in postmenopausal women plus low ferritin
☐ Yes ☐ No Rectal bleeding **without** anal *symptoms (anal symptoms include: soreness, discomfort, itching lumps and prolapsed as well as pain)*
☐ Yes ☐ No Change in bowel habit to looser stools and/or increased frequency of defecation, **without** rectal bleeding – persistent for 6 weeks

Recent colonoscopy: ☐ No ☐ Yes If yes, Date: DD/MM/YYYY Location: _____

☐ **Referral for Endoscopist or Surgical Consultation** (Preferences honoured provided consultation occurs within 14 days)

Preferred Endoscopist or Surgeon: ☐ First Available **or**
☐ Dr. R. Kareemi ☐ Dr. R. Suryavanshi
☐ Dr. A. Muhunthan ☐ Dr. P. Taylor
☐ Dr. A. Rudovics ☐ Dr. R. Syan
☐ Dr. A. Cornila

Fax completed form to 519-346-4608
CCATC Direct Line 519-464-4485