Sunnybrook
ODETTE CANCER CENTRE

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: ____________________________________

Address: _______________________________City/Province: _______________________ Postal code: ____________

PHYSICIAN INFORMATION

Referring Physician: ____________________________________ OHIP billing #: _______________________________

Bus. Tel: ____ Fax: _______________________________________

REFERRAL FOR COLORECTAL CANCER (or endoscopic suspected colorectal cancer)

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

☐ Colonoscopy ☐ Flexible Sigmoidoscopy ☐ Other: __________________

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

NOTE: THIS IS AN EXPEDITED PROGRAM - Please ensure your patient will attend the appointments to be scheduled within the next 1-2 months following receipt of referral. Inappropriate referrals will be sent back to the referring physician. Your patient will be contacted within 1-2 business days following receipt of referral

FOR MORE INFORMATION OR TO USE OUR e-REFERRAL, PLEASE VISIT:

sunnybrook.ca/colorectal

Version date August 6, 2020