



FIT AND COLORECTAL CANCER DIAGNOSTIC ASSESSMENT PROGRAM

PLEASE COMPLETE AND FAX REFERRAL FORM TO (416) 586-4853

PATIENT INFORMATION

Last Name:	First Name:	Date of Birth: <small>(MM / DD / YYYY)</small>
Health Card #:	Version:	Sex:
Address:	City:	Postal Code:
	Preferred Phone #:	

REASON FOR REFERRAL

Diagnosed Colorectal Cancer (*Full consult and plan to be provided within 1-2 weeks*)

- Palpable rectal mass
- Abnormal abdominal imaging highly suspicious for colorectal cancer
- Endoscopic findings suspicious for colorectal cancer/biopsy proven colorectal cancer

Symptoms highly suspicious for colorectal cancer (*Full consult and plan to be provided within 2-4 weeks*)

Positive fecal immunochemical test (FIT)

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

- Unexplained weight loss
- Change in bowel habits
- Unexplained iron-deficiency anemia
(Males Hb less than or equal to 110g/L; Post-menopausal Females Hb less than or equal to 100g/L)
- First degree family history of colorectal cancer
- Palpable abdominal mass

For positive FIT patients: Is on ANTICOAGULANTS? Yes No **Details:** _____

Oxygen dependent: Yes No

Sleep apnea with CPAP: Yes No

Stroke/Heart Attack: Yes No

Other: Please specify: _____

Cardiac pacemaker/defibrillator: Yes No

Severe heart failure Class 4: Yes No

Diabetic on medication: Yes No

Renal insufficiency: Yes No

No Mobility problems: Yes No

No Iron pills: Yes No

Please attach the patient's Cumulative Patient Profile (CPP), all relevant endoscopic and pathology reports and provide patient with CD of imaging studies.

Your office and the patient will be contacted with an appointment date.



FOR SURGICAL REFERRAL REQUEST

First Available Surgical Consultation Appointment or Specific Surgeon
NOTE: Wait times for surgeons listed below will vary

<input type="checkbox"/> Dr. Danielle Bischof	<input type="checkbox"/> Dr. Anthony De Buck	
<input type="checkbox"/> Dr. Mantaj Brar	<input type="checkbox"/> Dr. Alexandra Easson	<input type="checkbox"/> Dr. Erin Kennedy
<input type="checkbox"/> Dr. Savtaj Brar	<input type="checkbox"/> Dr. Anand Govindarajan	

REFERRING PHYSICIAN INFORMATION

Referring Physician :

Billing #:	Referral Date: <small>(MM / DD / YYYY)</small>
Office Phone:	Fax:

Please ensure your patient is aware of this referral as your patient will be contacted by the FIT/Diagnostic Assessment Program (DAP). The Booking Office can be reached at 416-586-4800 ext. 2099