NORTH YORK GENERAL
Making a World of Difference

Colorectal Cancer Diagnostic Assessment Program

Date of Referral:_____

Please note: Please ensure your patient is aware of this referral as they will be contacted by our navigator
Consider **referring early** - Staging will be expedited on behalf of our program

PATIENT INFORMATION		
Last Name:	First Name:	DOB:
OHIP :		Gender:
Address:	City:	Postal Code:
	Preferred Phone #:	

REFERRING PHYSICIAN	
Name:	Billing #:
Phone :	Fax :

REASON FOR REFERRAL

- ☐ New CRC
  - ○ Early Onset (<50 years old)
  - ○ Elder Onset (>70 year old)
- ☐ Second Opinion
- ☐ Symptoms highly suspicious for CRC
  - ○ Palpable rectal mass
  - ○ Positive fecal immunochemical test
  - ○ Suspicious rectal bleeding
  - ○ Abnormal Ultrasound/CT imaging results

History

Past Medical History

ENDOSCOPY PERFORMED – Please attach reports and pathology if available

☐ Colonoscopy	☐ Flexible Sigmoidoscopy

TUMOUR LOCATION

☐ Right	☐ Transverse
☐ Left or Sigmoid	☐ Rectum (<15cm from anus)

IMAGING

CT	☐ Chest	☐ Abdo / Pelvis
MRI	☐ Rectum	☐ Liver

Our Surgeons – ☐ Next available or specific to:

☐ Dr. Daniel Abramowitz	☐ Dr. Usmaan Hameed
☐ Dr. Stan Feinberg	☐ Dr. Peter Stotland

Program contact:
Fax (416) 756-6832
E-referral nygh.on.ca/colorectal/referral
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