Colorectal Diagnostic Assessment Program

Lakeridge Health
Telephone: (905) 576-8711 ext. 2340
Fax: 905-721-7784

The Colorectal Diagnostic Assessment Program will provide patients with timely access to an interdisciplinary team. Members of the team include: surgeon, pathologist, registered nurse and other health disciplines. Involvement of team members will be based on the reason for referral

Physician Information

Referring Physician
Name: _____
Address:_____
Phone: _____ Fax:_____
Physician Billing Number: _____

Family Physician:
Name: _____
Address:_____
Phone:_____ Fax:_____

Patient Information

HCN#: VC:	Unique #:	DOB (dd/mm/yyyy)
Surname:	Given Name:	Initials:
Address:		Postal Code
Home phone:	Work/Cell phone:	Alternate Contact

Medical Information

Endoscopy performed:	❑ Colonoscopy	❑ Flexible Sigmoidoscopy	Report available:	❑YES ❑ NO
Location of Tumor	❑ Right Colon	❑ Transverse Colon	❑ Left Colon or Sigmoid	❑ Rectum (<15 cm from anus)

Please select if initiated by referring physician:		**Please provide the following information if known:**			
No tests initiated. All staging to be initiated by Nurse Navigator	❑	Is referral to Medical and/or Radiation Oncology required at the time of this referral?			❑YES ❑NO
Blood Work *include results if outside LH	❑	Date of Surgical consult:		Date of Surgery:	
Biopsy/Pathology	❑	Other Clinical Information:			
CT Chest/Abd/Pelvis	❑				
MRI	❑				

Referral Request

Oshawa	**Bowmanville**	**Port Perry**
❑ Next Surgeon	❑ Next Surgeon	❑ Next Surgeon
Dr. _____	Dr. _____	Dr. _____

Complete Before Sending:

Referring Physician Signature: _____ Date of Referral: _____ (dd/mm/yy)

NOTE: Patient MUST be aware of this referral. Nurse Navigator will call patient in order to coordinate staging.