Hamilton Health Sciences
Diagnostic Assessment Program
COLORECTAL CANCER DAP REFERRAL

Phone: 905-521-2100 ext 76933 Fax: 905-308-7237

Patient's Last Name	First Name	
Address – Street	City	Postal Code
Telephone: ( )	Ext.	
Cell Phone: ( )		
Date of Birth (yyyy/mm/dd)	Age	Gender ☐ M ☐ F
HIN	Family Physician	

REFERRING PHYSICIAN

Name

Address

Phone

Fax

Health Care Provider Billing Number

Referral Date: (yyyy/mm/dd) ____________

Symptoms suggestive of colorectal cancer: ____________

____

____

ALARM FEATURES: (indicate all applicable)

Anemia: ☐ Microcytic anemia *(MCV value of 80 and below)* ☐ Documented Iron deficient

Rectal Bleeding: ☐ Bright Red Blood ☐ Maroon Blood

Abnormal Imaging results: *(relevant results **faxed with referral**)*

☐ CT Scan / Ultrasound suggestive of colorectal cancer ☐ Colonoscopy

Abnormal Test Results: (*relevant results **faxed with referral***) ____________

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ADDITIONAL ALARM FEATURES / CONCERNS (including co-morbidities): ____________

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Current Medication List: ☐ Faxed with Referral **Current Allergy List:** ☐ Faxed with Referral

Signature of Referring Physician ____________

In order for us to assess patients accurately, Referrals must be compete with all relevant results attached

FOR HHS USE ONLY

☐ Direct to Colonoscopy **OR** ☐ Consultation Required → **Patient has been triaged as:**

☐ **URGENT** (needs a referral within 1-2 weeks) **OR**

☐ **SEMI-URGENT** (needs a referral within 2-4 weeks)

Health Care Professional: ____________ ____________ ____________
(Medical Directive # 51002) (Printed Name) (Signature & Designation) (yyyy/mm/dd)

HHS ID Number ____________	Appointment Date (yyyy/mm/dd)	Appointment Time (hh:mm)

Appointment Confirmation Faxed	Date ____________ (yyyy/mm/dd)	Time ____________ (hh:mm)	By: (Print) ____________ (Signature) ____________

712524 (2016-09)

Referrals *(Sovera document type)*