Reset Form

Trillium Health Partners

Mississauga Halton Central West Regional Cancer Program
in partnership with Cancer Care Ontario

ACCT #:	
NAME:	
DOB:	
SEX:	PHONE#:
HC #:	
UNIT #:	

RECTAL DIAGNOSTIC ASSESSMENT PROGRAM REFERRAL FORM

Referral Date: _____ **Patient notified of diagnosis:** ☐ **Yes** ☐ **No**

RECTAL DAP FAX: 1- 877- 530- 4425 (Phone: 1- 866- 530- 4464)
Nurse Navigator: 905- 813- 1100 ext. 2934

REFERRAL INFORMATION:

Referring Physician Name and Specialty:	☐ GI ☐ General Surgeon ☐ Primary Care ☐ Emergency Physician ☐ _____	**Signature of Referring Physician:**
Physician Billing #:	Tel: ( )	Fax: ( )
Family Physician Name (if different from referring physician)	Tel: ( )	Fax: ( )

Refer to: ☐ **First available Rectal DAP Surgeon** **OR** ☐ **Dr. Andrew Burns** ☐ **Dr. Patrick Tawadros** ☐ **Dr. Neil Woolfson**

REASON FOR REFERRAL:

☐ **Mass less than 15 cm from anal verge on endoscopy** _____
☐ **Imaging report suggestive of rectal mass** _____
☐ **Rectal mass on physical exam** _____
☐ **Other:**_____

Relevant Clinical Information

**** We will complete all staging investigations. Please include any completed tests/endoscopy/pathology reports. ****

2830 D HR (April/2016)