UHN Toronto General Toronto Western Princess Margaret Toronto Rehab Michener Institute

CRC CARE Path®

Colorectal Cancer Comprehensive Assessment and Rapid Evaluation Pathway

URGENT REFERRAL FOR POSSIBLE COLORECTAL CANCER

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SECTION A. PATIENT INFORMATION

Last Name:	First Name:	Date of Birth (dd/mm/yyyy):	Gender: M F
Health Card #:	Version: / Patient Location Details (Home/Inpatient):	Previous UHN Patient: Yes NoMRN, if Known:	
Street Address:			
City:	Province:	Postal Code:	
Phone (Home):	Phone (Cell):	Phone (Work):	
Alternate Contact Name:	Relationship:	Phone (Home/Cell):	
Referring Physician Name:	Referring Physician Billing Number:	Referring Physician Phone:	Referring Physician Fax:
Referring Physician Email:	Family Physician Name:	Family Physician Phone:	Family Physician Fax:

SECTION B. To expedite the referral process, please include:

- ☐ history of patient
- ☐ description of current symptoms
- ☐ medications
- ☐ relevant bloodwork
- ☐ recent imaging reports
- ☐ pathology/cytology
- ☐ last endoscopic assessment/findings

SECTION C. The Problem: (reason to suspect Colorectal Cancer):

- ☐ Suspicious palpable rectal mass
- ☐ Suspicious abnormal abdominal imaging
- ☐ Risk factors for Colorectal Cancer
- ☐ Biopsy positive for Colorectal Cancer
- ☐ Clinical Symptoms Suspicious of Colorectal Cancer:
  - ☐ Unexplained rectal bleeding with one or more of the following features: dark blood, blood mixed with stool,absence of perianal symptoms
  - ☐ Weight loss
  - ☐ Change in bowel habits
  - ☐ Unexplained iron deficiency anemia
  - ☐ Positive FIT test (include FIT+ results), see below **

**** Asymptomatic patients with positive FIT tests may have referrals sent directly to: Division of Gastroenterology – TWH GI Clinic. Referral form is available for download at:** https://www.uhn.ca/UHNReferrals/TWH_GI_Clinic_Referral_Form.pdf

Other, please specify:_____

Please send SUSPICIOUS IMAGING IF AVAILABLE WITH Patient. Patients MUST ARRIVE ON TIME and bring with them their HEALTH CARD and X-RAY OR CT-SCAN IMAGES.

Date of Patient's initial consult with referring physician: _____
(mm/dd/yyyy)

Signature of Referring Physician (Mandatory) _____ **Date:** ____/____/_____