Toronto General
Toronto Western
Princess Margaret
Toronto Rehab

CRC CARE Path®

Colorectal Cancer Comprehensive Assessment and Rapid Evaluation Pathway

URGENT REFERRAL FOR POSSIBLE COLORECTAL CANCER

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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 No **MRN, 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:**

Please FAX consultant notes including HISTORY OF PATIENT, BLOOD WORK and CURRENT MEDICATIONS, X -RAY, CT SCAN, PATHOLOGY/CYTOLOGY & other PERTINENT REPORTS. **Patients MUST ARRIVE ON TIME and bring with them their HEALTH CARD and X-RAY OR CT-SCAN IMAGES.**

The Problem: (Reason to suspect Colorectal Cancer)

- ☐ Suspicious palpable rectal mass
- ☐ Risk factors for Colorectal Cancer
- ☐ Suspicious abnormal abdominal imaging
- ☐ 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 FOBT

Other specify :____

Please send SUSPICIOUS IMAGING IF AVAILABLE WITH PATIENT

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

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