Oakville Trafalgar Memorial Hospital

Colorectal
Diagnostic Assessment Program (DAP)
PATIENT REFERRAL

Please FAX completed form to: 905-338-4112

Patient Information (Please complete or affix sticker)

Name			
Address	Apt #	City/Town/Village	
Postal Code	Home Phone	Business Phone	
DOB:	❐ M ❐ F	HCN:	Exp:

Referral Information

Referring Physician	Billing #
Tel #	Fax #

IMPORTANT:
**** Please attach Patient Medical History and Medication List ****

Please indicate the location of the tumour:

- ❐ Cecum
- ❐ Ascending Colon
- ❐ Hepatic Flexure
- ❐ Transverse Colon
- ❐ Splenic Flexure
- ❐ Descending Colon
- ❐ Sigmoid Colon
- ❐ Rectosigmoid Colon
- ❐ Rectum
- ❐ Other: ______________________

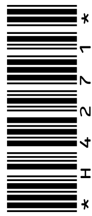
Please indicate the surgeon you would like to refer this patient to (Oakville):

- ❐ Dr. Nicole Callan
- ❐ Dr. Ian Choy
- ❐ Dr. Miles Kealey
- ❐ Dr. Qasim Khan
- ❐ Dr. Federico Pampaloni
- ❐ Dr. Duncan Rozario
- ❐ Dr. Manoj Sayal
- ❐ Dr. Sandra de Montbrun
- ❐ Next Available

IMPORTANT:
**** Please attach all relevant documentation including endoscopy reports, pathology, bloodwork, imaging ****

- ❐ Consult Notes
- ❐ Biopsy/Pathology Results
- ❐ Endoscopy Reports
- ❐ Imaging Results
- ❐ Lab Results

Signature of Referring Physician (mandatory):



Thank you for your referral. Our Patient Navigator will contact your office and your patient with instructions and appointment times for their assessment. If not contacted within 72 hours, please call our Patient Navigator at 905-845-2571 ext 3155.

For Office Use Only

Physician Assigned:	Date Received: ____ / ____ / ____ (MM DD YYYY)	Initial Contact with Patient: ____ / ____ / ____ (MM DD YYYY)
Hospital Site:	Medical Record Number:	