Trillium Health Partners

RECTAL DIAGNOSTIC ASSESSMENT PROGRAM REFERRAL FORM

Name: _____

Date of Birth: _____ Sex: _____

Healthcard Number: _____ Phone: _____

Address:

Referral Date: _____
MM/DD/YYYY

Patient notified of diagnosis: ☐ Yes ☐ No

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

Referral Information

Referring Physician Name: _____ Signature of Referring Physician: _____

Referring Physician Specialty:

☐ Gastrointestinal ☐ Primary Care
☐ General Surgeon ☐ Emergency Physician ☐ Other: _____

Physician Billing Number: _____ Telephone: _____ Fax Number: _____

Family Physician Name
(if different from referring physician): _____

Telephone: _____ Fax Number: _____

REASON FOR REFERRAL:

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

☐ 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. **