RECTAL DIAGNOSTIC ASSESSMENT PROGRAM (DAP)
REFERRAL FORM

ROYAL VICTORIA REGIONAL HEALTH CENTRE
201 GEORGIAN DRIVE, BARRIE, ONTARIO L4M 6M2
Phone: 705-728-9090 ext. 43519 Fax: 705-739-5636

***** Only referrals from Surgeon or Colonoscopist are accepted *****

PATIENT INFORMATION			
Surname	First Name	Gender ☐F ☐ M	D.O.B dd/mm/yy
Address	City/Province	Postal Code	Phone Number
RVH V# (if applicable)	OHIP # (with version code)	Patient's Email	
Name of Patient's Preferred Pharmacy		Name of Family Physician	

Patient Details/Significant Medical History:

Only colonoscopy confirmed tumors <15cm from anal verge accepted.

Mass is_____ cm from anal verge.

Surgeon referral required: ☐ Yes ☐ No Surgeon name:_________________

Colonoscopy Date & Location:_______________________

Routine Orders (Select what NEEDS to be ordered)	**Attached**	**Pending**	**If pending, date and facility:**
☐ CT Chest / Abdo / Pelvis	☐	☐	
☐ MRI Rectum (if tumor <15cm by scope)	☐	☐	
☐ Colorectal Lab Set & CEA (CBC, Creatinine, Electrolytes, BUN, LFT, LDH)	☐	☐	
☐ Oncologist Consult if Indicated by MCC	☐	☐	
Diagnostic information:			
☐ Colonoscopy report	☐	☐	
☐ Pathology sent	☐	☐	

REFERRING PROVIDER INFORMATION		
Referring Physician Name	Billing #	Date
Address	Phone Number	Fax Number
Referring Physician Signature		

Please inform ALL patients of referral.

Your patient will be contacted directly with appointment details.

Please FAX Referral to 705-739-5636