Simcoe Muskoka Regional Cancer Program

RVH Royal Victoria Regional Health Centre

A Cancer Care Ontario Partner

SUSPICION OF CANCER, THORACIC OR RECTAL DIAGNOSTIC ASSESSMENT PROGRAM (DAP) REFERRAL

SIMCOE MUSKOKA REGIONAL CANCER PROGRAM
201 GEORGIAN DRIVE, BARRIE, ONTARIO L4M 6M2
www.rvh.on.ca

Please Complete Patient Information, Select the appropriate DAP & Include Provider Information

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)	Does patient identify as Aboriginal? ☐ Yes Special assistance required: ☐ Interpreter ☐Visually impaired ☐Hearing impaired	

Is the patient on anticoagulants? ☐No ☐ Plavix ☐ASA ☐Fragmin ☐Other, **Specify:**

Is the patient on bronchodilators? ☐No ☐ Yes

Patient Details/Significant Medical History:

☐ **THORACIC DAP** **(For patient pamphlet click here or visit www.rvh.on.ca)** **Phone: 705-728-9090 ext 43519**

CT must be ordered for all patients referred to the thoracic DAP

CT: ☐ Completed & Attached ☐ Ordered. If ordered, Date & Location of Upcoming CT: _____

Reason for Referral:

☐ Abnormal Imaging:
Date of Imaging:_____ Location: _____ Type: ☐ Chest X-Ray ☐ CT ☐ Other _____

☐ Concerning Symptoms: _____

☐ **RECTAL DAP *Only referrals from Surgeon or Colonoscopist accepted** **Phone: 705-728-9090 ext 43519**

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:_____

	Attached	Pending	If pending, date and facility
Routine Orders (Select what NEEDS to be ordered)			
☐ CT Chest / Abdo / Pelvis	☐	☐	_____
☐ MRI Pelvis (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	☐	☐	_____

☐ **SUSPICION of Cancer DAP** **(For patient pamphlet click here or visit www.rvh.on.ca)** **Phone: 705-728-9090 ext 43144**

Reason for cancer suspicion: _____

Clinical documents:	**Attached**	**Pending**	**If pending, date and facility**
Patient history and consult notes	☐	☐	_____
Lab	☐	☐	_____
Imaging	☐	☐	_____
Cardio/pulmonary	☐	☐	_____

REFERRING PROVIDER INFORMATION

Name	Phone	Fax
Address	Date	Billing #
Family Physician:		Referring Physician Signature

Please inform ALL patients of referral. SMRCP will contact patient directly with appointment details

Fax: 705-739-5636

October 2018