Simcoe Muskoka Regional Cancer Program
RVH Royal Victoria Regional Health Centre

Ontario Health

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 Indigenous? ☐ 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 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:__________

Routine Orders (select what NEEDS to be ordered):	Attached	Pending	If pending, please list date and facility
☐ 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 visit www.rvh.on.ca) — Phone: 705-728-9090 ext 43144

Reason for cancer suspicion: ____________________

Clinical documents:	Attached	Pending	If pending, please list 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

Last Updated: October 2021