waterloo wellington regional cancer program
in partnership with cancer care ontario

GI DIAGNOSTIC ASSESSMENT PROGRAM
Nurse Navigator Referral/Order Form

Please complete ALL information and fax to 519-749-4384
***** Patient must be aware of diagnosis prior to referral *****

PATIENT'S PERSONAL INFORMATION (or affix patient demographics sticker)

Name:		Date of Referral:
Address:	Apt. #:	City, Town, Village:
Postal Code:	Home Phone #: Business/Other Phone #:	Date of Birth:

HEALTH INSURANCE INFORMATION

Is patient covered under the Ontario Health Insurance Plan? ☐ Yes ☐ No Full name on Health Card:_____	Health Card Number	Version code	Exp date

REFERRAL INFORMATION (To be completed and signed by referring physician):

Patient notified of diagnosis: Y____ N____

Referring Physician's Name:	Tel: ( )	Fax: ( )

Surgeon referred to by Gastroenterologist (if applicable):

ROUTINE ORDERS (Please check boxes and fax back to Nurse Navigator for processing)

■ Colorectal lab set and CEA (set includes CBC, Cr, lytes, BUN, LFT and LDH) **Note: Provide an outside lab requisition and CEA fee exemption form to patients who live outside the K-W area**.
■ CT Chest/Abd/Pelvis
☐ Rectal tumour <15 cm by Scope.
■ MRI Pelvis (If tumour <15cm by scope).
☐ Greater than 320lbs (145kg) = CT scan limitation

Physician signature:	
Transcribed by:	
Nursing signature:	

Complete section if data available

Relevant History:

Date of referral to your office: _____/____/_____
year month day

Date of colonoscopy: _____/____/_____ **Where the colonoscopy was done:**
year month day

Is the patient (check all that apply):
☐ On blood thinner
☐ Diabetic
☐ Able to sign consent? If no, substitute decision maker:_____
☐ Allergic to contrast
☐ Taking Metformin

Please contact Nurse Navigator at 519-749-4300 ext. 3783 (leave voicemail if required) of impending referral.
Fax referral to 519-749-4384.

Draft version 4 Jan, 2013	Legend ☐ Optional items/orders ■ Mandatory