High Risk Rectal Bleeding Pathway for Colorectal Cancer Diagnosis – Referral Checklist

Patient label placed here (if applicable) or if labels are not used, minimum information below is required.

Name (last, first) _____

Birthdate (yyyy-Mon-dd) _____

Phone number _____

Address _____

PHN _____ Gender _____

Fax referral form AND referral checklist below to FAST in Edmonton at 780-670-3224 or GI-CAT in Calgary at 403-944-6540

REQUIRED FOR REFERRAL - Symptoms of high risk rectal bleeding *(check all that apply)*

Symptoms of high risk rectal bleeding:

- ☐ Blood visibly present in stool, OR in the toilet, AND not just on the tissue paper, AND
- ☐ New onset, OR worsening and persistent rectal bleeding (not a single episode, present most days of the week for more than 2 weeks)
- ☐ Bleeding is unexplained (i.e. absence of complete colonoscopy within last 2 years)

REQUIRED FOR URGENT REFERRAL - Rectal Bleeding as described above, AND

- ☐ Palpable abdominal or rectal mass, OR
- ☐ Suspected colorectal lesion or evidence of metastases seen on imaging

REQUIRED FOR SEMI-URGENT REFERRAL – Rectal Bleeding as described above, AND

At least one of the following alarm features *(check all that apply)*

- ☐ New or worsening anemia (Hb <130g/L in men, Hb <120g/L in women)
- ☐ Iron deficiency (serum ferritin <45 ug/L)
- ☐ New onset, persistent or worsening abdominal pain
- ☐ New onset or progressive unintentional weight loss (≥5-10% of body weight over 6 months)
- ☐ Concerning change in bowel habit

INVESTIGATIONS THAT WILL ASSIST WITH TRIAGE *(check all that apply)*

Medical History

- ☐ Personal/Family history of colorectal cancer or inflammatory bowel disease (please provide details)

  _____
- ☐ Results of most recent lower endoscopic examination (please attach)

Baseline Investigations within 8 weeks of referral – results attached?:

☐ **CBC (Required)** ☐ Serum Iron ☐ TIBC ☐ Creatinine ☐ Serum Ferritin

Type of referral	**Is your patient aware of the referral?**
☐ Urgent (<2 weeks to colonoscopy) ☐ Semi-urgent (<8 weeks to colonoscopy)	☐ Yes ☐ No

Referred By (Name): _____ Family Physician Name (if different): _____

☐ Family Physician ☐ Walk-In Clinic ☐ Emergency Dept. ☐ Other

OFFICE USE ONLY:

Referral Complete ☐ Yes ☐ No Referral Re-Directed to Another Program ☐ Yes ☐ No