Central Referral Office
Send Referral by Fax: 204-786-0621
Inquiry? Call: 1-844-320-4545

GASTROINTESTINAL Oncology Referral Guide

(Anal, Biliary Duct, Carcinoid, Colorectal, Gall Bladder, Gastric, Hepatocellular and Pancreas)

NOTE: This checklist is provided as a guide and is not intended as clinical guidance.

REQUIRED INFORMATION TO COMPLETE PATIENT TRIAGE

Please send a copy of the original results/reports if available or indicate the date and location if ordered.

GI DSG Disease	Requirements	Required/Preferred
Colon and Appendix (including colorectal)	☐ Pathology report with cancer diagnosis	**Required**
	☐ CT abdomen and pelvis	**Required**
	☐ Colonoscopy report	**Required**
	☐ CT chest	**Preferred**
	☐ History and Physical exam from referring MD	**Preferred**
	☐ Name of involved or consulted surgeon (if not metastatic)	**Preferred**
Rectal	☐ Pathology report with cancer diagnosis	**Required**
	☐ Colonoscopy report	**Required**
	☐ MRI or EUS for staging	**Required**
	☐ CT abdomen and pelvis	**Required**
	☐ CT chest	**Preferred**
	☐ Name of involved or consulted surgeon (if not referred by surgeon and not metastatic)	**Preferred**
Gastric	☐ Pathology report with cancer diagnosis	**Required**
	☐ Endoscopy report	**Required**
	☐ CT abdomen and pelvis	**Required**
	☐ History and physical exam from referring MD	**Preferred**
	☐ CT chest	**Preferred**
	☐ Name of involved or consulted surgeon (if not referred by surgeon and not metastatic)	**Preferred**

GI DSG Disease	Requirements	Required/Preferred
Pancreas	☐ Bloodwork including CA19-9 and total bilirubin	**Required**
	☐ CT (or MRI) of abdomen and pelvis, CT chest	**Preferred**
	☐ History and Physical exam from referring MB	**Preferred**
	☐ Pathology report	**Preferred**
	☐ Early Palliative Care: If applicable, indicate if a conversation about palliative care for pancreatic cancer took place with the patient and provide some details. ☐ Yes ☐ No Additional information:	**Preferred**
Anal SCC (Anal small cell carcinoma	☐ Pathology with cancer diagnosis	**Required**
	☐ CT abdomen and pelvis	**Required**
	☐ History and Physical Exam	**Preferred**
	☐ CT chest	**Preferred**
Others including GI primary unknown or NET	☐ CT or MRI abdomen and CT chest	**Preferred**
	☐ History and Physical examination by referring MD	**Preferred**
	☐ Pathology report	**Preferred**

ADDITIONAL INFORMATION

Please send a copy of the original results/reports if available or indicate the date and location if ordered.

Pathology & Operative Reports	☐ FNA biopsy - cytology ☐ Core biopsy
Blood work	☐ CBC ☐ CEA ☐ Biochemistry, LFTs ☐ Alphafetoprotein (for Hepatocellular Cancer)
Diagnostic Imaging	☐ Abdominal X-Ray ☐ Chest X-Ray ☐ Barium Enema ☐ ES&D ☐ ERCP (for Hepatobiliary Cancer and Pancreatic Cancers) ☐ Cholangiogram ☐ Ultrasound
Other information	☐ Hospital discharge summary, if applicable

Additional support for clinicians is available at the Cancer Question Helpline for Health Care Professionals:
Call/Text: 204-226-2262 Email: cancerquestion@cancercare.mb.ca **Web:** cancercare.mb.ca/cancerquestion