

Affix patient label within this box

## Rectal Assessment Checklist

- To ensure your referral is triaged correctly, please complete the following checklist for all patients referred with colorectal symptoms.

### Part A - Mandatory for any Referral with Rectal Bleeding

When was the first time the bleeding was seen?

- Weeks ago                       Months ago                       Years ago

What color is the blood?

- Bright red                       Dark red                       Black

Frequency (*how often is the **blood** seen?*)

- Less than once a month  
 About once or twice a month  
 About once a week  
 Most days of the week

Where is the blood seen? (*Check all that apply*)

- On the toilet paper  
 On the outside of the stool  
 Down in the toilet  
 Mixed inside the stool

### Part B - Mandatory for all Colorectal Referrals

Does the patient have new onset                       Diarrhea                       Constipation

Does the patient have anemia?                       No                       Yes ► HGB \_\_\_\_\_ Date (*yyyy-Mon-dd*) \_\_\_\_\_

Does the patient have weight loss greater than 10 pounds in the last 3 months?                       No                       Yes

Is there a history of colorectal cancer in a first degree relative under the age of 70?

No                       Yes ► If Yes, age of the affected relative \_\_\_\_\_

Findings on digital rectal examination                       Normal                       Abnormal

If **Abnormal**, please describe

Date of Last colonoscopy (*yyyy-Mon-dd*) \_\_\_\_\_

Never had a colonoscopy

Additional information