Cancer Centre of Southeastern Ontario
A Cancer Care Ontario Partner

Kingston Health Sciences Centre | Centre des sciences de la santé de Kingston

NEW PATIENT REFERRAL

Phone: 613-544-2631 ext. 4510
Fax : 613-546-8214

HELP US TO SPEED UP YOUR PATIENT'S JOURNEY BY INCLUDING ALL SUPPORTING INFORMATION

PATIENT INFORMATION

Last Name	First Name	DOB (yyyy/mm/dd)	Sex ☐ F ☐ M ☐ Other	
OHIP/Version Code or Other Insurance	Address	City	Province	Postal Code

Home Telephone ( )	Work Telephone ( )	Extension	Mobile Telephone ( )

Alternative Contact Person	Home Telephone ( )	Work Telephone ( )	Ext.	Mobile Telephone ( )

Does the patient have special needs? ☐ Oxygen ☐ Wheelchair ☐ Stretcher ☐ Transfer Service
☐ Interpretation – Language:_____ ☐ Other _____

Primary Care Provider	Primary Care Provider Phone ( )	Primary Care Provider Fax ( )

Is the patient aware they are being referred to the Cancer Centre? ☐ Yes ☐ No, reason

REFERRAL INFORMATION

Primary Site

☐ Breast ☐ CNS ☐ GI ☐ GU ☐ Gynecology ☐ Head and Neck
☐ Hematology ☐ Lung ☐ Lymphoma ☐ Melanoma ☐ Sarcoma ☐ Skin
☐ Unknown Primary ☐ Suspected Cancer ☐ Other, specify _____

REASON FOR REFERRAL

If referring for a clinical trail, list protocol # or NCT # if known:

CLINICAL INFORMATION (Details regarding supporting information on the next page.)

REPORTS:	Attached	Pending	If Pending Source/Date
Detailed Referral Letter	☐	☐	
Operative Report	☐	☐	
Pathology Reports	☐	☐	
Blood Work	☐	☐	

IMAGING:	Attached	PCS	Pending	If Pending Source/Date
CT Scan	☐	☐	☐	
Chest X-Ray	☐	☐	☐	
Ultra Sound	☐	☐	☐	
Bone Scan	☐	☐	☐	
Mammogram	☐	☐	☐	
MRI	☐	☐	☐	
Other	☐	☐	☐	

Referring Care Provider Name	Referring Care Provider Signature (Mandatory)	Date (yyyy/mm/dd)

Referring Care Provider Telephone ( )	Ext.	Referring Care Provider Fax ( )	Referring Care Provider Email

KGH CCSEO OFFICE USE ONLY	Appointment	Physician	Date (yyyy/mm/dd)	Time (hh/mm)	Clinic
	Appointment	Physician	Date (yyyy/mm/dd)	Time (hh/mm)	Clinic
	Appointment	Physician	Date (yyyy/mm/dd)	Time (hh/mm)	Clinic

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Supporting Information

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Fax Referral: 613-546-8214

Referrals are booked to the first available oncology appointment (usually within 2 weeks). **FOR EMERGENCY REFERRALS THE REFERRING PHYSICIAN MUST CALL 613-549-6666 TO SPEAK WITH THE ONCOLOGIST.**

To expedite the referral process please include:

- Pathology reports
- Recent imaging
- Bloodwork
- Prior pathology (if any malignant diagnosis)
- Referral letter indicating current symptoms, the history of the present illness, past medical history and medications.

Special Cases:

- When referring for **a suspected cancer** recent imaging, bloodwork and referral letter are all that is needed.
- No testing is required for patients with **Sarcoma**.

Instructions for using this form:

This form can be printed and filled in by hand. Alternatively, it can be completed electronically using Adobe Reader and printed. The filled in form can be saved using the paid version of Adobe Acrobat.

The mouse can be used to navigate the form. Alternatively, the Tab key can be used to move forward through fields on the form. Holding Shift + Tab together will navigate the curser to the previous field. Check boxes can be marked or cleared using the space key.

Abbreviation	Definition
DOB	Date of birth
OHIP	Ontario Health Insurance Plan
Ext.	Extension
CNS	Central nervous system
GI	Gastrointestinal
GU	Genitourinary
CT	Computed tomography
MRI	Magnetic resonance imaging
PCS	QuadraMed Patient Care System
NCT	National Clinical Trials