

# NEW PATIENT REFERRAL

Ph: 613-544-2631 ext. 4510  
Toll free: 1-800-567-5722  
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 <input type="checkbox"/> F   <input type="checkbox"/> 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?		<input type="checkbox"/> Oxygen	<input type="checkbox"/> Wheelchair	<input type="checkbox"/> Stretcher	<input type="checkbox"/> Transfer Service
		<input type="checkbox"/> Interpretation – Language: _____			<input type="checkbox"/> 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					
<b>Primary Site</b>					
<input type="checkbox"/> Breast	<input type="checkbox"/> CNS	<input type="checkbox"/> GI	<input type="checkbox"/> GU	<input type="checkbox"/> Gynecology	<input type="checkbox"/> Head and Neck
<input type="checkbox"/> Hematology	<input type="checkbox"/> Lung	<input type="checkbox"/> Lymphoma	<input type="checkbox"/> Melanoma	<input type="checkbox"/> Sarcoma	<input type="checkbox"/> Skin
<input type="checkbox"/> Unknown Primary	<input type="checkbox"/> Suspected Cancer	<input type="checkbox"/> Other, specify _____			
REASON FOR REFERRAL					
If referring for a clinical trial, list protocol # or NCT # if known:					
CLINICAL INFORMATION (Details regarding supporting information on the next page.)					
<b>REPORTS:</b> Attached Pending If Pending Source/Date			<b>IMAGING:</b> Attached PCS Pending If Pending Source/Date		
Detailed Referral Letter		_____	CT Scan	_____	
Operative Report		_____	Chest X-Ray	_____	
Pathology Reports		_____	Ultra Sound	_____	
Blood Work		_____	Bone Scan	_____	
Up to Date Medication List		_____	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	
<b>OFFICE USE ONLY</b>	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

## Supporting Information

Phone Inquiry: 613-544-2631 ext. 4510

Toll Free: 1-800-567-5722

Fax Referral: 613-546-8214



Referrals are booked to the first available oncology appointment (usually within 2 weeks). **THE REFERRING PHYSICIAN MUST CALL TO SPEAK WITH THE ONCOLOGIST FOR EMERGENT CASES WHERE THE PATIENT NEEDS TO BE SEEN WITHIN 24 HOURS.**

### 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 current list of 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 cursor 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