

Benign Hematology Clinic Referral Form

Simcoe Muskoka Regional Cancer Program

201 GEORGIAN DRIVE, BARRIE, ONTARIO L4M 6M2

Phone: 705-728-9090 Ext. 23200

Fax: 705-797-3098

Date of Referral (D/M/Y): _____

PATIENT INFORMATION				
Last Name	First Name	Gender <input type="checkbox"/> F <input type="checkbox"/> M	D.O.B D/M/Y	Preferred Phone Number
Address	City/Province	Postal Code	OHIP # (with version code)	
Other Contact Person or POA (Name & Phone Number), if applicable:				

REFERRAL INFORMATION AND SUPPORTING DOCUMENTATION	
Reason For Referral:	Recent CBC: HGB: _____ WBC: _____ ANC: _____ PLTS: _____

The following information is required, please include in the referral package. Incomplete referral forms will delay appropriate triage and referral time

- Referral Letter/ History & Physical
- Relevant Labs (ALL available CBCs, genetic testing, iron studies)
- Previous Consultation (GI, Hematology, Medicine)
- Relevant Imaging
- List of Current Medications

Additional History/Previous Treatment:

REFERRING PROVIDER INFORMATION		
Name	Billing#	Direct Line:
Phone	Ext.	Fax #:

Referring Physician Signature:

Please fax completed form to 705-797-3098