

OUTPATIENT ONCOLOGY NEW PATIENT REFERRAL

Fax your completed form and the minimum referral clinical information to **FAX: 705-792-3325**

PATIENT INFORMATION				
Last Name	First Name	Gender <input type="checkbox"/> F <input type="checkbox"/> M	D.O.B d/m/y	Phone
Address	City/Province	Postal Code	OHIP # (with version code)	
RVH V# (if Applicable)	Patient's email	Name of Preferred Pharmacy:		
Family Physician	Family Physician Phone	Any special assistance required: <input type="checkbox"/> Interpreter <input type="checkbox"/> Visually Impaired <input type="checkbox"/> Hearing Impaired		
Consult Request <input type="checkbox"/> Radiation Oncology <input type="checkbox"/> Medical Oncology <input type="checkbox"/> Most Appropriate Disease Site (see below page for Urgent Referral Process) <input type="checkbox"/> Breast <input type="checkbox"/> CNS <input type="checkbox"/> G.I. <input type="checkbox"/> G.U. <input type="checkbox"/> Gyne <input type="checkbox"/> Hematology <input type="checkbox"/> Lung <input type="checkbox"/> Skin <input type="checkbox"/> Other: Has Patient had Previous Cancer Treatment? <input type="checkbox"/> No <input type="checkbox"/> Yes – Facility: _____ <p style="text-align: center;">URGENT REFERRALS, select the indication below and contact: Weekdays 8:00am-4:00pm 705-728-9090 EXT 43334 Weekends and afterhours, hospital switchboard at 705-728-9090</p> <input type="checkbox"/> Acute Leukemia <input type="checkbox"/> Brain Metastasis <input type="checkbox"/> Spinal Cord Compression <input type="checkbox"/> Urgent/Emergent				
INVESTIGATIONS				
To expedite the referral process please include: history of the present illness, current symptoms, medications, procedure report, pathology report, blood work, recent imaging and prior pathology of any malignant dx.				
Reports:	Attached	Pending	If pending, list date and facility.	
Referral Letter	<input type="checkbox"/>	<input type="checkbox"/>	_____	
Operative Report	<input type="checkbox"/>	<input type="checkbox"/>	_____	
Pathology Report	<input type="checkbox"/>	<input type="checkbox"/>	_____	
Blood Work	<input type="checkbox"/>	<input type="checkbox"/>	_____	
Other	<input type="checkbox"/>	<input type="checkbox"/>	_____	
Imaging:	Attached	Pending	If pending, list date and facility.	
Bone Scan	<input type="checkbox"/>	<input type="checkbox"/>	_____	
CT	<input type="checkbox"/>	<input type="checkbox"/>	_____	
X-Ray	<input type="checkbox"/>	<input type="checkbox"/>	_____	
Mammo	<input type="checkbox"/>	<input type="checkbox"/>	_____	
MRI	<input type="checkbox"/>	<input type="checkbox"/>	_____	
Ultra Sound	<input type="checkbox"/>	<input type="checkbox"/>	_____	
Other	<input type="checkbox"/>	<input type="checkbox"/>	_____	
Additional Information:				
REFERRING PROVIDER INFORMATION				
Name	Phone	Fax	OHIP Billing #	
Address	Date	Signature		
Please ensure your patient is aware of diagnosis & referral. Patients will be contacted directly with appointment info. The appointment will be within 14 days. If your patient is unavailable in the next 14 days please refer at a more appropriate time. Our office will send you fax confirmation within 72 hours of processing.				