Halton Healthcare
GEORGETOWN • MILTON • OAKVILLE

Oakville Trafalgar Memorial Hospital

Cancer Clinics
PATIENT REFERRAL

Please include pathology, operative, imaging and consult reports

Telephone: 905-338-4635 **Fax: 905-338-4114**

Name: _____ M / F
SURNAME, GIVEN NAME

Address: _____
STREET (APT)

_____ _____ _____
CITY PROVINCE POSTAL CODE

Phone: (H)_____ (W/C) _____

D.O.B: _____/_____/_____Health Card #:_____
DD / MM / YY INCLUDING VERSION CODE

Unit #:_____

Alternate Contact	Relationship	Primary Phone #

Patient Location

❒ Home

❒ Hospital: Name: _____ IP Unit: _____ Unit Extension: _____

Family Physician Name	Physician Number	Telephone #	Fax #

REQUESTED SERVICES

❒ Hematology
❒ Medical Oncology
❒ Palliative Care (Cancer Diagnosis)

CHOOSE PRIMARY SITE

❒ Hematologic ❒ Lymphoma ❒ Breast ❒ G.I. ❒ G.U.
❒ Lung ❒ Prostate ❒ Skin ❒ Unknown Primary ❒ Other: _____

REASON FOR REFERRAL (confirm patient is aware of reason for referral) - ❒ Yes – Diagnosis: _____

❒ New Patient ❒ 2nd Opinion ❒ Recurrent/Progressive ❒ Urgent: _____

Previous Cancer Treatment: ❒ No

❒ Yes – Please provide treatment details and date: _____

Investigations Booked (Include details of dates and testing facility):

_____

_____

Please include referral letter, pathology, operative report(s), lab work, any radiology reports pertaining to diagnosis.
Any missing information/reports WILL delay the processing of this referral.

_____ _____ _____ _____
Referring Physician Name Physician Number Telephone # Fax #

Signature of Referring Physician (mandatory): _____ Date: _____

H4101

For Office Use Only

Date Received: _____ / _____ / _____
Day Month Year

Information received complete: ❒ Yes ❒ No

Triaging ❒ Nurse / ❒ Doctor: _____

Date given for Triage: _____ / _____ / _____
Day Month Year

Date Meditech ONC Software intake completed: _____ / _____ / _____
Day Month Year

Status Update Complete: ❒ Yes ❒ No