



ONCOLOGY REFERRAL FORM

Outpatient Cancer Care Clinic
Halton Healthcare
3001 Hospital Gate
Oakville, ON L6M 0L8

Please **COMPLETE ALL INFORMATION** and
FAX TO 905-338-4376 WITH ALL RELATED REPORTS

Patient's Surname:	Given Name:	
Health Card Number or non-OHIN information:	Version Code:	Does patient require translator? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, language?

Sex: Male Female Other: D.O.B: (DD/MM/YYYY)

Street (Apt) City Province Postal Code

Phone (primary) Phone (Secondary)

Patient Location: Home Hospital Hospital / Inpatient Unit / Unit Extension

Alternate Contact:	Relationship:	Phone:
Referring Physician:	Fax:	Phone:
Family Physician:	Fax:	Phone:

Note: This patient remains under the care of the referring physician until seen by Oncologist at the Cancer Clinic

Diagnosis:	Patient Informed of Diagnosis: <input type="checkbox"/> Yes <input type="checkbox"/> No	ARO Status: <input type="checkbox"/> Unknown	MRSA <input type="checkbox"/> Pos VRE <input type="checkbox"/> Pos
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Requested Service(s): <input type="checkbox"/> Medical Oncologist <input type="checkbox"/> Hematology Oncologist <input type="checkbox"/> Radiation Oncologist <input type="checkbox"/> Palliative Care Physician	Primary Site: <input type="checkbox"/> Breast <input type="checkbox"/> G.U. <input type="checkbox"/> Primary Unknown <input type="checkbox"/> Prostate <input type="checkbox"/> Melanoma <input type="checkbox"/> Hematology (Specify): <input type="checkbox"/> Lung <input type="checkbox"/> Skin (Non-Melanoma) <input type="checkbox"/> GI <input type="checkbox"/> Gyne(Specify): <input type="checkbox"/> Other (Specify):
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Reason for Referral: <input type="checkbox"/> New <input type="checkbox"/> Recurrent/Progressive <input type="checkbox"/> 2nd Opinion	Previous Cancer Treatment: <input type="checkbox"/> No <input type="checkbox"/> Yes (provide previous records) <input type="checkbox"/> Chemotherapy <input type="checkbox"/> Radiation <input type="checkbox"/> Other:
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Investigations Scheduled Include Date & Testing Facility:	Investigations Completed and Faxed/Available Electronically: *REQUIRED FOR REFERRAL with other staging investigations					
	Reports:	Faxed	Clinical Connect	Radiology:	Faxed	Clinical Connect
_____	*Referral Letter/H&P	<input type="checkbox"/>	<input type="checkbox"/>	MRI	<input type="checkbox"/>	<input type="checkbox"/>
_____	*Operative/Scopes	<input type="checkbox"/>	<input type="checkbox"/>	Ultrasound	<input type="checkbox"/>	<input type="checkbox"/>
_____	*Pathology Reports	<input type="checkbox"/>	<input type="checkbox"/>	Bone Scan	<input type="checkbox"/>	<input type="checkbox"/>
_____	*Blood Work	<input type="checkbox"/>	<input type="checkbox"/>	CT Scan	<input type="checkbox"/>	<input type="checkbox"/>
_____	Pulmonary Function	<input type="checkbox"/>	<input type="checkbox"/>	Mammogram	<input type="checkbox"/>	<input type="checkbox"/>
Note: Any missing information may delay processing of this referral	X-Ray	<input type="checkbox"/>	<input type="checkbox"/>	Receptors	<input type="checkbox"/>	<input type="checkbox"/>

Referring Physician Name (Printed)

Signature of Referring Physician (Mandatory)

Date (DD/MM/YYYY)

FOR OFFICE USE ONLY

Date Complete Referral Received: (DD/MM/YYYY) Appointment Date: Time:

Oncologist:

Appointment Given to: Patient Referring MD Other (Specify): Completed on Date: (DD/MM/YYYY) Initials:



To avoid delays in processing this referral, please request the following additional tests or include the following reports if already completed per disease site.

Disease Site	Additional Recommended Investigations with Reports and Test Results
Breast	<ul style="list-style-type: none"> ○ ER/PR/HER2 results and surgeon's note for locally advanced breast cancer ○ PET scan for patients with locally advanced disease (T3N0, T2N1, T3N1, any N2, any T4) ○ CT chest/abdomen/pelvis for Stage 3-4 disease ○ Bone Scan (for patients not undergoing PET Scan) for Stage 3-4 disease
Colon	<ul style="list-style-type: none"> ○ CT chest/abdomen/pelvis; MRI rectum, MRI or ultrasound liver ○ CEA, Ca 19-9 levels ○ NGS/Molecular testing (RAS, BRAF) and MMR testing on pathology specimen
Other Gastrointestinal	<ul style="list-style-type: none"> ○ CT chest/abdomen/pelvis ○ Bloodwork: Ca19-9 level ○ PET scan with localized/locally advanced esophageal or GEJ cancer, anal SCC ○ Diagnostic laparoscopy: gastric cancer ○ MMR testing on pathology specimen ○ NGS/Molecular testing (Her2, PD-L1, FGFR) on pathology specimen for: gastroesophageal cancers, cholangiocarcinoma
Genitourinary	<ul style="list-style-type: none"> ○ CT chest/abdomen/pelvis, Bone Scan ○ Bloodwork: PSA, total testosterone results ○ NGS/Molecular testing (BRCA/ATM, FGFR) on pathology specimen for: Prostate, urothelial carcinoma
Hematology	<p><u>Multiple Myeloma/MGUS</u></p> <ul style="list-style-type: none"> ○ Blood work: CBC, Creatinine, Calcium, LFT's, Quantitative immunoglobulins, serum immunofixation, SPEP, Serum Free Light chain studies, UPEP ○ Skeletal survey, CT, MRI if done <p><u>Lymphoma</u></p> <ul style="list-style-type: none"> ○ Bloodwork: CBC, Creatinine, Calcium, LFT's ○ CT neck, chest, abdo, pelvis with contrast <p><u>Lymphocytosis</u></p> <ul style="list-style-type: none"> ○ Bloodwork: CBC, calcium, Creatinine, LFTs, flow cytometry on peripheral blood ○ US or CTs if done <p><u>Myeloproliferative Disorders</u></p> <ul style="list-style-type: none"> ○ Bloodwork: CBC, Creatinine, Calcium, LFTs
Thoracic/Lung	<ul style="list-style-type: none"> ○ CT chest/abdomen/pelvis, Bone Scan, MRI brain ○ PET scan for localized/locally advanced disease ○ Surgical opinion report, if available ○ Molecular studies (EGFR/ALK/PD-L1) ○ Other consultant opinions, if available

