ONCOLOGY REFERRAL FORM

Please include pathology, operative and consult reports.
Also include any recent imaging reports.

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

Patient Demographics

Patient's Surname: | Given Name:

Does patient require translator? If so, language? ______________________________

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

Street (Apt) | City | Province | Postal Code

Home# | Work# | Health Card Number: | Version Code

Alternate Patient Contact Name: | Relationship: | Primary Phone #:

Patient Location: ☐ **Home** ☐ **Hospital**______________________________
Hospital / Inpatient Unit / Unit Extension

Referring Physician Name:	Physician Number:	Telephone #:	Fax #:
Family Physician Name:	Physician Number:	Telephone #:	Fax #:

Please note this patient remains under the care of the referring physician until seen by a physician at the Cancer Clinic

Choose Requested Service(s):

☐ Medical Onc. - **Path. required**
☐ Radiation Onc. **(Satellite Clinic)**
☐ Palliative Care **(Cancer Diagnosis)**
☐ Hematology

CHOOSE PRIMARY SITE:

☐ Breast ☐ Melanoma ☐ G.U.
☐ Prostate ☐ Skin (Non-Melanoma) ☐ Lymphoma
☐ Haematologic ☐ Gyne ☐ Unknown Primary
☐ Lung ☐ G.I. ☐ Other (Specify):

Reason for Referral (PLEASE ENSURE PATIENT IS AWARE OF REASON FOR REFERRAL)

☐ New ☐ 2nd Opinion
☐ Recurrent/Progressive

Previous Radiation? ☐ Yes Body Site: ______________
Previous Chemo? ☐ Yes ______________________

Please provide previous records with referral.

INVESTIGATIONS BOOKED: Include Date & Testing Facility

Please include referral letter, pathology report(s), operative report(s), blood work results (if applicable) and ALL radiology reports that pertain to the referred patient's diagnosis. ANY missing information/reports WILL delay the processing of this referral (see page 2).

______________________________ ______________________
Signature of Referring Physician (Mandatory) **Date**

FOR OFFICE USE ONLY

Date Received: __________________
(DD/MM/YY)

☐ Appointment: Date: ______________ Time:____________ Physician: ______________________

☐ Other action: ____

Appointment Given to: ☐ Patient ☐ Referring MD on Date:________________ Initials:________________
☐ Other

To avoid delays in processing this referral, please include the following reports and test results per disease site.

Please include pathology, operative and consult reports to avoid delays.
Also, please include any recent imaging reports and previous chemotherapy records.

Disease Site	**Recommended Reports and Test Results**
Breast	○ Pathology report ○ ER/PR/HER2 results; Include surgeon's note for Locally Advanced Breast Cancer ○ Any staging investigation reports, if available
Gastrointestinal	○ Consult/progress notes ○ OR notes ○ Imaging result-CT/MRI/U/S etc. ○ Pathology results ○ Molecular markers (KRAS, BRAF)
Genitourinary	○ Note stating the reason for referral ○ Surgical notes ○ Pathology report ○ Imaging results, if available ○ PSA results, if available
Haematology	Rule out Multiple Myeloma/MGUS ○ Blood work (CBC, Creatinine, Calcium, SPEP, Quantitative immunoglobulins, Light chain studies, UPEP) ○ Skeletal survey, if available Lymphocytosis ○ CBC ○ Flow cytometry, if available Lymphoma ○ Pathology reports, if available ○ Radiology guided biopsy report, if available ○ Imaging results, if available
Thoracic/Lung	○ Pathology report ○ Radiology reports ○ PET scan report, if available ○ Surgical opinion report, if available ○ Molecular studies (EGFR/ALK/PDL1), if available ○ Other consultant opinions, if available