Thunder Bay Regional Health Sciences Centre
Regional Cancer Care Northwest
Patient Referral Form

Phone: 807-684-7294
Fax: 807-346-8383

Mandatory Area **MUST** be completed or referral will be rejected

MANDATORY		
Reason for Referral: ☐ **ONCOLOGY (Medical or Radiation)** ☐ **Hematology** ☐ **Diagnostic Assessment**		
DIAGNOSIS: **Patient Informed of Diagnosis:** ☐ **Yes** ☐ **No**	**Have you consulted with Oncologist:** ☐ **Yes** ☐ **No** **Name:** **Date:**	
***Urgency:** ☐ **Emergency** (Seen within 24 hours) ☐ **Urgent** (Seen within 72 hours) ☐ **Standard** (Seen with 2 weeks)	*Please see referral guidelines on back page to identify referral type	
Minimum Required Information: (see back for additional information that may be required) ☐ **Pathology report(s)** ☐ **Patient demographics** ☐ **Consult letter** ☐ **Other** – see back page **Note: Include only those reports for investigations conducted outside Thunder Bay Regional Health Sciences Centre.**		
PATIENT INFORMATION – please fill in or apply patient demographic sticker		
Last Name	**Given Name(s)**	
Address:	**City/Prov/Postal Code:**	
☐ **Male** ☐ **Female** **DOB:** **Age:**	**Health Card Number**	
Home Telephone	**Work Telephone**	
Alternate Contact	**Relationship**	**Telephone**
☐ **Translator Needed /Language required** ☐ **Telehealth Appointment needed /Reason:**	**Patient location:** ☐ **Home** ☐ **In Patient - Hospital** **Name:**_____	
CLINICAL INFORMATION – Please attach additional sheets as needed		
Clinical Information:		
Surgery (Date, Hospital, Procedure):		
Previous Cancer Treatment: ☐ **No** ☐ **Yes** ☐ **Chemotherapy** ☐ **Radiation Therapy** **Site:**_____		
REFERRING PROVIDER INFORMATION		
Name	**Telephone**	
Family Physician	**Fax Number**	
Physician Signature (MANDATORY)	**Telephone**	
Note: Patients remain under the care of the referring physician until seen by an Oncologist.		

Thunder Bay Regional Health Sciences Centre
Regional Cancer Care Northwest
Patient Referral Form

Phone: 807-684-7294
Fax: 807-346-8383

Oncology Referrals must be accompanied by:

- Pathology reports documenting cancer diagnosis **(if not performed at TBRHSC)**
- A consultation letter highlighting presenting signs, symptoms and findings
- Completed referral form

Please indicate if test/reports are in progress and note date of the procedure and location on the referral form.
Cancer Site Specific Information is required for staging and is important to ensure patients can be treated as quickly as possible. For information on sites not listed, or if you **require assistance to achieve a diagnosis**, please call the new patient referral office at (807) 684-7294 or toll free at (877) 696-7223.

BREAST	**Additional Investigations** **Copies only if investigations were not done at TBRHSC**	**Diagnostic Assistance Required?**
☐ History ☐ Examination ☐ Operating room reports ☐ Pathology ☐ Estrogen/progesterone results ☐ Mammogram	**Stage 1 and DCIS**-no further investigations **Stage II** ☐ CBC/LFT's ☐ <4 nodes – bone scan ☐ =>4 nodes – bone scan, ultrasounds adbo/liver and chest X-ray **Stage III & IV** ☐ Bone scan ☐ Ultrasound adbo/liver ☐ Chest x-ray ☐ CBC/LFT's	
LUNG		
☐ Brief history ☐ Examination ☐ Chest X-ray ☐ Bronchoscopy (if done) ☐ Operating room note (if done) ☐ Pathology ☐ Chest/liver/adrenals ☐ Pulmonary function test ☐ Blood work: CBC/electrolytes/LFT's/Creatinine	**Imaging Reports**: ☐ Current and old chest x-rays ☐ CT scan ☐ Bone scan ☐ PET Reports (if done)	
Gastrointestinal		
All available recent X-ray films and reports related to current presenting problems	**Colon:** ☐ Chest x-ray, ☐ CT chest/adbo/pelvis	
Genitor-urinary		
Lab Reports: ☐ **Prostate**-All PSA levels ☐ **Testes**-HCG, AFP, LDH (pre and post op)	Imaging Reports ☐ **Prostate**-Bone scan If done ☐ **Bladder**-Cysto ☐ -CT Pelvis ☐ **Testes**-Chest X-ray ☐ -CT abdo/pelvis ☐ **Kidney**-Chest X-ray ☐ -Bone Scan ☐ -CT Abdomen	
Note: Patients remain under the care of the referring physician until seen by an Oncologist.		

***REFERRAL TYPE DEFINITIONS (please use these guidelines to correctly identify the referral type)**

Standard Referral Seen within 2 weeks of referral for patients requiring consultation with a Medical or Radiation Oncologist for **consideration of treatment options.**

Urgent Referral Seen within 72 hours from time of referral. Please call to discuss with the RCC-NW attending physician. For patients who require immediate chemotherapy or radiation therapy to avoid **potential oncological emergencies**.

Emergency Referral Seen within 24 hours. Please call to discuss with the RCC-NW attending physician. For patients requiring immediate chemotherapy or radiation therapy for a **life threatening oncological emergency.**