|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **MANDATORY AREAS MUST BE COMPLETED OR REFERRAL WILL BE RETURNED FOR COMPLETION** | | | | | | | | | |
| **Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Service Requested:**  **Medical Oncology  Radiation Oncology  Hematology  Palliative Care Oncology  Palliative Care Non-oncology** | | | | | | | | | |
| **DIAGNOSIS:**  **Patient Informed of Diagnosis:**  **Yes**  **No** | | **Have you consulted with Oncologist:**  **Yes**  **No**  **Name: Date:** | | | | | | | |
| **\*Urgency:**  **Emergency**  **Urgent**  **Standard**  **(Seen within 24 hours) (Seen within 72 hours) (Seen with 2 weeks)** | | | | | | \*Please see reverse to identify referral type and guidelines for what must accompany referral | | | |
| **Reason For Consultation:**  **New Diagnosis**  Recurrent/Progressive Disease  Second Opinion  MCC Clinical Question Only  COMMENTS: | | **Primary Site:**  **Breast**  **Gyne**  **Lung**  **G.I.**  **G.U.**  **CNS** | | | | **Primary Site:**  **Hematology**  **Sarcoma**  **Melanoma**  **Skin**  **Head & Neck**  **Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | |
| **PATIENT INFORMATION MANDATORY –MUST BE >18 YEARS OF AGE – please fill in or apply patient demographic sticker** | | | | | | | | | |
| **Last Name** | | **Given Name(s)** | | | | | | | |
| **Address** | | **Date of Birth** | | | | | | | |
| **Male**  **Female** | | **Health Card Number or non OHIN Info** | | | | | **Version Code** | | |
| **Home Telephone** | | **Work Telephone** | | | | | | | |
| **Alternate Contact** | | **Relationship** | | | | **Telephone** | | | |
| **Translator Needed /Language required**  **Telemedicine Appointment needed /Reason:** | | **Patient location:**  **Home**  **In Patient - Hospital**  **Facility:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | |
| **CLINICAL INFORMATION – Please attach additional sheets as needed** | | | | | | | | | |
| **Surgery (Date, Hospital, Procedure):**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Investigations Scheduled (including date and facility):**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **Reports Included:**  Referral Letter/H&P  Operative/Scopes  Pathology  X-Ray  Ultrasound  Bone Scan | | | Meditech | €  €  €  €    € | Bloodwork  PFT’s  CT Scan  MRI  Mammogram  Hormone  receptors | | Meditech |  |
| **Previous Cancer Treatment:**  **No**  **Yes**  **Chemotherapy**  **Radiation Therapy**  **Other Facility:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | | | |
| **REFERRING PROVIDER INFORMATION** | | | | | | | | | |
| **Name** | | | **Telephone** | | | | | | |
| **Family Physician** | | | **Fax Number** | | | | | | |
| **Physician Signature (MANDATORY)** | | | **Telephone** | | | | | | |

**\*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.**