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| **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 OnlyCOMMENTS: | **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&POperative/ScopesPathologyX-RayUltrasoundBone Scan | Meditech **[ ]** **[ ]** **[ ]** **[ ]** **[ ]** **[ ]**  | **[ ]** €**[ ]** €**[ ]** €**[ ]** €**[ ]** **[ ]** € | BloodworkPFT’sCT ScanMRIMammogramHormone 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.**