CANCER CARE CLINIC
REFERRAL FORM

Cancer Care Clinic Phone: 416-242-1000 ext. 21500 **Cancer Care Clinic Fax:** 416-242-1068

Date of Referral: ___________________________ **Cancer Diagnosis:** _______________________________

NOTE: The following information **MUST BE INCLUDED** with this referral:

- ☑ Pathology report (include tumor markers)
- ☑ Consult notes
- ☑ Operative report
- ☑ Imaging results
- ☑ Recent bloodwork
- ☑ Current medication list

Referral Source: ☐ HRH Breast Clinic ☐ Family Physician ☐ Oncologist Office ☐ Other

Patient Information (please print clearly):

Last Name:	**First Name:**	**Patient Known to HRH?** ☐Yes ☐ No **MRN/H# (if available):**
Date of Birth:	**Health Card Number:**	**Version Code:**
Home Address:		
City:	**Province:**	**Postal Code:**
Home Phone:	**Cell Phone:**	**Work Phone:**
Alternate Contact:	**Relationship to Patient:**	**Phone:**

Language Spoken: ______________________________ **Interpreter Required?** ☐ Yes ☐ No

(**Note:** patient should be accompanied by family, friend or Substitute Decision-Maker on initial oncology clinic visit and patient teaching session)

Reason for Referral (check all that apply):

☐ New cancer diagnosis *Date of Diagnosis*: __________________________________

☐ Secondary cancer diagnosis *Date of Diagnosis*: __________________________________

☐ Recurrent disease ☐ Progressive/malignant disease ☐ Clinical trials

☐ Other (specify): ____

Relevant Clinical Information: **(FAX all reports, consult notes, previous cancer related treatment reports (chemotherapy or radiation), bloodwork, imaging results, list of current medications with this referral)**

Referring Physician Information (please print clearly):

Referring Physician:	**Billing Number:**	**Phone Number:** **Fax Number:**
Family Physician:	**Phone Number:**	

(For HRH Cancer Clinic Use Only):

Referral To: (specify Oncologist/Hematologist) ____

Referral Received On:	**Appointment Date and Time:**	**Name of HRH Oncologist:**
Patient Teaching (*book AFTER oncologist consult)* *Teaching must be booked prior to first treatment visit*	**Date of Patient Teaching Booked:**	**Time of Patient Teaching Booked:**
Staff Name:	**Signature:**	**Date:**

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