Odette Cancer Centre
Fax-in Referral Form
June/08

Date of Referral: MM / DD / YY

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Please fax form and documents to
New Patient Booking Office
Fax (416) 480 - 6179

OCC OFFICE USE ONLY	OCC #	SHSC #
Clinic Booked:	Date Booked:	Time Booked:
Clinic appointment called to:	☐ Referring Physician ☐ Hospital	☐ Patient ☐ Other (specify)

BONE METASTASIS CLINIC
FOR REFERRAL PLEASE CALL (416) 480-4205

****THIS PATIENT REMAINS UNDER THE CARE OF THE REFERRING PHYSICIAN UNTIL SEEN BY AN ONCOLOGIST AT OUR CENTRE****

Patient Surname:	Given Name:	Birth Date (Y/M/D):
Street (Apt.#)	City:	Postal code:
Home: ( )	Work: ( )	Other Contact Person's Name: Tel: ( )
Does Patient Speak English ☐ Yes ☐ No ☐ Other (specify):	Patient Location: ☐ Home ☐ Hospital (specify):	
OHIN Number:	Version Code:	
Referring Physician Name:	Tel: ( )	Fax: ( )

Please fill in all relevant details:

CANCER DIAGNOSIS: _____

REASON FOR REFERRAL:

1) Does the patient have a known history of Bone Metastases? Yes / No

2) Primary region of the body affected by Bone Metastases you are seeking an opinion regarding:

☐ **Spine** ☐ **Femur** ☐ **Arm** ☐ **Other:** _____

Has radiation been given to this site: Yes / No

3) Are there any other body sites with KNOWN Bone Metastases: Yes / No

If Yes: ☐ **Spine** ☐ **Femur** ☐ **Arm** ☐ **Other:** _____

4) Does this patient have known NON-Bony Metastases: Yes / No

Sunnybrook
ODETTE CANCER CENTRE