Odette Cancer Centre Fax-In Referral Form

Please **FAX** *form and documents to New Patient Booking Office:*
(416) 480-6179

Date of Referral: ____________________

Site:
☐ Breast ☐ Breast Diagnostic ☐ CNS
☐ Familial Breast ☐ Familial Melanoma ☐ G.I.
☐ G.U. ☐ Gynaecology ☐ Haematology
☐ Head & Neck ☐ Lung ☐ Melanoma
☐ Pigmented Lesion ☐ Skin ☐ Other (specify)

Specific Service Required: ☐ Radiation Oncology ☐ Medical Oncology ☐ Surgical Oncology ☐ Breast Diag/Genetic Testing ☐ Second Opinion

Diagnosis:

☐ **Emergency/Urgent** (*within 48 hours*)

Patient Information:

Last Name:________________________________First Name:____________________________________
OHIP#: _______________________________ Version Code:______ DOB(*D/M/Y*):____/____/_________
Sex: M / F Does patient speak English? ☐Yes ☐No ☐ Other (specify):______________________
Address:____________________________________City__________________Postal Code___________
Home Phone:_________________________________Business/Cell Phone:_________________________
Patient Location: ☐ Home ☐ Hospital (specify):____
Other Contact Person Name and Phone Number:

Doctor Information:

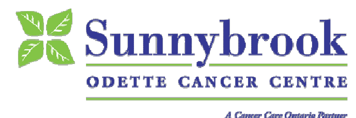
Referring Physician:____________________________________Billing #:______________________
Phone:____________________ ext.__________*Direct Line*:___________________ *Fax*:___________________
Family Physician:____________________________________
Phone:____________________ ext.__________ *Direct Line*:___________________ *Fax*:___________________
Surgeon:____
Phone:____________________ ext.__________*Direct Line*:___________________ *Fax*:___________________

Referral Information and Supporting Documentation:

Patient Informed of Diagnosis? ☐**Yes** ☐**No**	Date of surgery/biopsy (*D/M/Y*)___/___/_________ ☐ N/A
Specific OCC oncologist?☐ No ☐ Yes (specify)	
Treatment Setting: ☐ New ☐ Recurrent/Progressive ☐ Other: ______________________________	
Date of Previous anti-cancer treatments: ☐**Chemotherapy**________☐**Hormonal Therapy**_________☐**Other(specify)**_______________	
Date of Current anti-cancer treatments: ☐**Chemotherapy**________☐**Hormonal Therapy**_________☐**Other(specify)**_______________	
NOTE: This patient remains under the care of the referring physician until seen by an oncologist at OCC.	

REMINDER: Please send the following, if available:

Reports:	*Faxed*	*Pending*	Radiology Imaging:	*Faxed*	*Pending*
Referral Letter/H&P	☐	☐	Chest X-Ray	☐	☐
Operative/Brochoscopy	☐	☐	Other Plain Film	☐	☐
Pathology Reports	☐	☐	Ultrasound	☐	☐
X-Ray Reports	☐	☐	Bone Scan	☐	☐
Chemo Schedules	☐	☐	CAT Scan	☐	☐
Blood Work	☐	☐	Mammogram	☐	☐
Pulmonary Functions	☐	☐	Receptors	☐	☐
			MRI	☐	☐



Phone Number: (416) 480-4205

We will contact the referring doctor with an appointment.

Referring Physician Signature:

____

OCC OFFICE USE ONLY		TSRCC Reference:		SHSC Reference:	
Clinic Booked:		Date Booked:		Time Booked:	
Clinic Booked		Date Booked		Time Booked	
Clinic appointment called to:	Referring Physician Hospital	Patient Other (specify)		Slide Review Requested:	Yes No