

Odette Cancer Centre Fax-In Referral Form

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

Date of Referral (YYYY/MM/DD): _____

PATIENT IDENTIFICATION

Site: Breast Familial Breast G.U. Head & Neck Pigmented Lesion
 Breast Diagnostic Familial Melanoma Gynaecology Lung Skin
 CNS G.I. Haematology Melanoma 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: Male Female _____ 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 (YYYY/MM/DD): _____ 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.

OCC OFFICE USE ONLY HFN Number: _____
 Clinic Booked: _____ Date Booked: _____ Time Booked: _____
 Clinic Booked: _____ Date Booked: _____ Time Booked: _____
 Clinic appointment called to: Referring Physician Hospital Patient Other (specify): _____

Phone Number: (416) 480-4205
We will contact the referring doctor with an appointment.

REMINDER: Please send the following, if available:

Reports	Faxed	Pending	Radiology Imaging	Faxed	Pending
Referral Letter/H&P	<input type="checkbox"/>	<input type="checkbox"/>	Chest X-Ray	<input type="checkbox"/>	<input type="checkbox"/>
Operative/Brochoscopy	<input type="checkbox"/>	<input type="checkbox"/>	Other Plain Film	<input type="checkbox"/>	<input type="checkbox"/>
Pathology Reports	<input type="checkbox"/>	<input type="checkbox"/>	Ultrasound	<input type="checkbox"/>	<input type="checkbox"/>
X-Ray Reports	<input type="checkbox"/>	<input type="checkbox"/>	Bone Scan	<input type="checkbox"/>	<input type="checkbox"/>
Chemo Schedules	<input type="checkbox"/>	<input type="checkbox"/>	CAT Scan	<input type="checkbox"/>	<input type="checkbox"/>
Blood Work	<input type="checkbox"/>	<input type="checkbox"/>	Mammogram	<input type="checkbox"/>	<input type="checkbox"/>
Pulmonary Functions	<input type="checkbox"/>	<input type="checkbox"/>	Receptors	<input type="checkbox"/>	<input type="checkbox"/>
			MRI	<input type="checkbox"/>	<input type="checkbox"/>

