Sunnybrook
ODETTE CANCER CENTRE
A Cancer Care Ontario Partner

Palliative Radiotherapy/Rapid Response Clinic Fax-In Referral Form

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

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

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 IDENTIFICATION

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:_____

Referring Physician:_____ Tel:_____ Fax:_____

Family Physician:_____ Tel:_____ Fax:_____

SITE OF PRIMARY CANCER: _____ **Please fill in all relevant details**

Pathology report (confirming cancer)

Date (YYYY/MM/DD)	Location Performed	Arrangement for sending to OCC			OCC received		OCC re-request	OCC received
		Patient	Fax	Courier	YES	NO		

Progress reports indicating treatment to date

Date (YYYY/MM/DD)	Location Performed	Arrangement for sending to OCC			OCC received		OCC re-request	OCC received
		Patient	Fax	Courier	YES	NO		

REASON FOR REFERRAL (Check all that apply)

PAINFUL BONE METASTASES ***Ensure imaging comes from correct location (e.g. bone scan from NuclearMed Dept)**

Painful Site # 1	Relevant imaging	Date (YYYY/MM/DD)	Location Performed*	Arrangement for sending to OCC			OCC received		OCC re-request	OCC received
				Patient	Fax	Courier	YES	NO		
Painful Site # 2	Relevant imaging	Date (YYYY/MM/DD)	Location Performed*	Arrangement for sending to OCC			OCC received		OCC re-request	OCC received
				Patient	Fax	Courier	YES	NO		

BRAIN METASTASES Imaging showing brain metastases: _____

Date (YYYY/MM/DD)	Location Performed	Arrangement for sending to OCC			OCC received		OCC re-request	OCC received
		Patient	Fax	Courier	YES	NO		

SPINAL CORD OR CAUDA EQUINA COMPRESSION: Imaging showing compression: _____

Date (YYYY/MM/DD)	Location Performed	Arrangement for sending to OCC			OCC received		OCC re-request	OCC received
		Patient	Fax	Courier	YES	NO		

OTHER: _____ Imaging documenting other cancer-related problem: _____

Date Date (YYYY/MM/DD)	Location Performed	Arrangement for sending to OCC			OCC received		OCC re-request	OCC received
		Patient	Fax	Courier	YES	NO		

OCC OFFICE USE ONLY HFN Number:_____

Clinic Booked:_____ Date Booked:_____ Time Booked:_____

Clinic appointment called to: ☐ Referring Physician ☐ Hospital ☐ Patient ☐ Other (specify): _____