Sunnybrook
ODETTE CANCER CENTRE
A Cancer Care Ontario Partner

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
- ☐ 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
- ☐ Surgical Oncology
- ☐ Medical 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	☐	☐	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	☐	☐

PR 47201
(2016/08/05)