NORTH YORK GENERAL

Making a World of Difference

HEMATOLOGY / ONCOLOGY PATIENT REFERRAL FORM

TELEPHONE 416 – 756 - 6949

FAX 416 – 756 – 6557

PATIENT INFORMATION

Last Name:	First Name:	Date of Birth (dd/mm/yyyy):	Gender:

Health Card #:	Version:	Interpreter Services Required? ☐ No ☐ Yes: please specify ____________________

Street Address:

City:	Province:	Postal Code:
Phone (Home):	Phone (Cell):	Phone (Work):
Alternate Contact Name:	Relationship:	Phone (Home/Cell):

Referring Physician Name:	Referring Physician Billing Number:	Referring Physician Phone:	Referring Physician Fax:
Referring Physician Signature:	Family Physician Name:	Family Physician Phone:	Family Physician Fax:

REASON FOR REFFERAL:

(Please include as much information as possible and FAX COPIES OF ALL CONSULTATION/CLINCAL NOTES & REPORTS)

Requested Service:

☐ Oncology

- ☐ Breast
- ☐ Lung
- ☐ Colon
- ☐ Other ____________
- ☐ Adjuvant
- ☐ Metastatic
- ☐ 2nd Opinion

☐ Hematology

- ☐ Lymphoma
- ☐ Leukemia
- ☐ Myeloma
- ☐ Benign Hematology
- ☐ Other _____________

Specific Physician?

☐ First available

☐ Yes:

- ☐ Dr. Paula Fishman
- ☐ Dr. Vivian Glenns
- ☐ Dr. Sarah Ingber
- ☐ Dr. Danny Robson
- ☐ Dr. Daryl Roitman
- ☐ Dr. Jeff Silverman
- ☐ Dr. Joanne Yu

Patient Informed of Diagnosis?

☐ Yes ☐ No

Date Sent: __________________________

Please include the following, if available:

- ☐ Blood work
- ☐ Pathology results
- ☐ X-rays
- ☐ CT / MRI/ ultrasound
- ☐ Bone scan
- ☐ Mammograms
- ☐ Consult Notes
- ☐ Tumor Markers

FOR OFFICE USE ONLY

- ☐ Benign
- ☐ Malignant
- ☐ Unknown

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NOTE: THIS PATIENT REMAINS UNDER THE CARE OF THE REFERRING PHYSICIAN UNTIL SEEN AT NYGH.