

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? <input type="checkbox"/> No <input type="checkbox"/> 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 REFERRAL:

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

<p>Requested Service:</p> <p><input type="checkbox"/> Oncology</p> <p style="margin-left: 20px;"><input type="checkbox"/> Breast <input type="checkbox"/> Adjuvant</p> <p style="margin-left: 20px;"><input type="checkbox"/> Lung <input type="checkbox"/> Metastatic</p> <p style="margin-left: 20px;"><input type="checkbox"/> Colon <input type="checkbox"/> 2nd Opinion</p> <p style="margin-left: 20px;"><input type="checkbox"/> Other _____</p> <p><input type="checkbox"/> Hematology</p> <p style="margin-left: 20px;"><input type="checkbox"/> Lymphoma</p> <p style="margin-left: 20px;"><input type="checkbox"/> Leukemia</p> <p style="margin-left: 20px;"><input type="checkbox"/> Myeloma</p> <p style="margin-left: 20px;"><input type="checkbox"/> Benign Hematology</p> <p style="margin-left: 20px;"><input type="checkbox"/> Other _____</p>	<p>Specific Physician?</p> <p><input type="checkbox"/> First available</p> <p><input type="checkbox"/> Yes:</p> <p style="margin-left: 20px;"><input type="checkbox"/> Dr. Paula Fishman</p> <p style="margin-left: 20px;"><input type="checkbox"/> Dr. Vivian Glens</p> <p style="margin-left: 20px;"><input type="checkbox"/> Dr. Sarah Ingber</p> <p style="margin-left: 20px;"><input type="checkbox"/> Dr. Danny Robson</p> <p style="margin-left: 20px;"><input type="checkbox"/> Dr. Daryl Roitman</p> <p style="margin-left: 20px;"><input type="checkbox"/> Dr. Jeff Silverman</p> <p style="margin-left: 20px;"><input type="checkbox"/> Dr. Kathryn Towns</p> <p style="margin-left: 20px;"><input type="checkbox"/> Dr. Joanne Yu</p> <p>Patient Informed of Diagnosis?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Date Sent: _____</p>	<p>Please include the following, if available:</p> <p><input type="checkbox"/> Blood work</p> <p><input type="checkbox"/> Pathology results</p> <p><input type="checkbox"/> X-rays</p> <p><input type="checkbox"/> CT / MRI/ ultrasound</p> <p><input type="checkbox"/> Bone scan</p> <p><input type="checkbox"/> Mammograms</p> <p><input type="checkbox"/> Consult Notes</p> <p><input type="checkbox"/> Tumor Markers</p> <hr/> <p align="center">FOR OFFICE USE ONLY</p> <p><input type="checkbox"/> Benign</p> <p><input type="checkbox"/> Malignant</p> <p><input type="checkbox"/> Unknown</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>
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