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 ☐ Adjuvant
- ☐ Lung ☐ Metastatic
- ☐ Colon ☐ 2nd Opinion
- ☐ Other _____

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

Specific Physician?

☐ First available
☐ Yes:
- ☐ Dr. Paula Fishman
- ☐ Dr. Vivian Glenns
- ☐ Dr. Sarah Ingber
- ☐ Dr. Jeffrey Myers
- ☐ Dr. Danny Robson
- ☐ Dr. Daryl Roitman
- ☐ Dr. Jeff Silverman
- ☐ Dr. Kathryn Towns
- ☐ 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

_____
_____
_____
_____

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