

**ADCP New Patient Referral Form**

**Fax – (705) 541-7803**

**Telephone- (705) 541-7807**

**INCOMPLETE OR UNSIGNED REFERRALS WILL NOT BE PROCESSED.**

**PATIENT INFORMATION (Please Print) All information MUST be completed**

Surname		Given Name(s)	
<b>Date of Birth</b> ____/____/____ dd mm yy	<b>Gender</b> <input type="checkbox"/> Male <input type="checkbox"/> Female	OHIN# (incl Version Code)	
Address		City / Province	Postal Code
Patient's Telephone Home _____ Work _____ Cell _____		Contact Person Name _____ Home _____ Work _____ Cell _____	
Family Provider: Phone: _____ Fax: _____		Where to contact patient: <input type="checkbox"/> Home <input type="checkbox"/> Hospital <input type="checkbox"/> Other (specify) _____	

**Cancer Program will notify patient of appointment**

**CLINICAL INFORMATION**

**The following information is required in order for this referral to be accepted and processed\*:**

Final Confirming Pathology	Surgical Report
Consult and Progress Notes	Discharge Notes
History and Physical Notes	All Lab work Related to Diagnosis

\*Pathology may not be required for a Radiation Oncology referral for palliative radiation. Pathology may not be required for Medical Oncology referral, at the discretion of the Medical Oncologist on call.

No clinical information is required "For AET review".

**REFERRAL INFORMATION**

Referral to: <input type="checkbox"/> Radiation Oncology To request OTN Consultation for Radiation Oncology check here <input type="checkbox"/>  <input type="checkbox"/> Medical Oncology If patient is symptomatic or needs urgent assessment, contact the NPAT Department at (705) 541-7807 and speak to the Oncologist on call		Date of Last Surgery ____/____/____ dd mm yy  Is Further Surgery Planned? <input type="checkbox"/> Yes <input type="checkbox"/> No
Diagnosis	Patient Informed of Diagnosis? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Newly Diagnosed <input type="checkbox"/> Recurrent or Progressive Disease <input type="checkbox"/> For Adjuvant Endocrine Therapy (AET) Review
Referring Physician's Name (Print)	Physician Referral Number	Referring Physician Tel: Fax:
Today's Date ____/____/____ dd mm yy	Signature / Stamp of Referring Physician ( <b>Mandatory</b> )	

NOTE: This is a **CONTROLLED** document as are all files on this server. Any documents appearing in paper form are not controlled and should **ALWAYS** be checked against the server file versions (electronic version) prior to use

**Health Records – Do Not Destroy**



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Page 1 of 1