DEMOGRAPHIC LABEL

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)
Date of Birth ____/____/____ dd mm yy	**Gender** ☐ Male ☐ 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: ☐ Home ☐ Hospital ☐ 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: ☐ Radiation Oncology To request OTN Consultation for Radiation Oncology check here ☐ ☐ 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? ☐ Yes ☐ No
Diagnosis	Patient Informed of Diagnosis? ☐ Yes ☐ No	☐ Newly Diagnosed ☐ Recurrent or Progressive Disease ☐ 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 **(Mandatory)**	