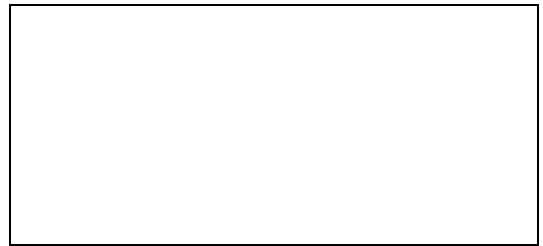




Oncology Clinic Referral



Phone Inquiry: 613 - 969 – 7400 (ext. 2380)

FAX: 613 - 961 – 2503

Date: _____ Time: _____ hour <small>DD/MM/YYYY</small>	<i>Oncology Clinic Use: Date Referral Received</i>
Consult to Oncologist: • Emergent: (within 24 hrs.) • Urgent: (within 24 – 72 hrs.) • Standard: (within 2 weeks)	
Disease Site: ___ .Breast ___ . G.I. ___ . Lung ___ . Prostate ___ . Hematology ___ . Lymphoma ___ . Unknown Primary ___ . Other (specify)	
Reason: 	
Patient Demographics: Male: • Female: • Age:	
Last name: First name: Middle initial:	
Health Card # • Date of Birth: Phone # <small style="margin-left: 300px;">DD/MM/YYYY</small>	
Address: City: Postal Code:	
Hearing Loss Interpreter Required: • No • Yes Language:	
<i>We recommend that a family member or close friend accompany the patient on their first visit</i>	
_____ () – () – () Referring Physician (please print) Signature (mandatory) Phone #	
<i>Oncology Clinic Use</i>	
Dear Dr: _____ Thank you for the referral and your patients consult appointment is booked on: _____ <small style="margin-left: 450px;">DD/MM/YYYY</small> Comment: _____ _____	