Oncology Clinic Referral

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

FAX: 613 - 961 – 2503

Date: _____ Time: _____ hour DD/MM/YYYY	*Oncology Clinic Use: Date Referral Received*

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 #
DD/MM/YYYY

Address: City: Postal Code:

Hearing Loss Interpreter Required: · No · Yes Language:

We recommend that a family member or close friend accompany the patient on their first visit

_____ _____ ( ) – ( ) – ( )

Referring Physician (please print) Signature (mandatory) Phone #

Oncology Clinic Use

Dear Dr: _____

Thank you for the referral and your patients consult appointment is booked on: _____
DD/MM/YYYY

*Comment:*_____

_____