

Scarborough Systemic Therapy Program

New Patient Referral Form

Please fax form and documents to New Patient Booking Office

Fax (416) 431-8279

Phone (416) 431-8113

MEDICAL ONCOLOGY CONSULT REQUEST

RADIATION ONCOLOGY CONSULT REQUEST

Patient Surname:		Given Name:		Male <input type="checkbox"/> Female <input type="checkbox"/>			
Street (Apt. #):		City:		Postal Code:			
Home # ()		Work # ()		Other Contact Name:			
Birth Date (D/M/Y):		Does patient speak English? Yes <input type="checkbox"/> No <input type="checkbox"/>		Tel # ()			
Health Card # (include VC)		Other (specify)		Patient Location: <input type="checkbox"/> Home <input type="checkbox"/> Hospital (specify)			
Referring Physician Name:		Tel:		Fax:			
Family Physician Name:		Tel:		Fax:			
Surgeon Name:		Tel:		Fax:			
Treatment Setting <input type="checkbox"/> Newly diagnosed cancer <input type="checkbox"/> Recurrent/progressive disease <input type="checkbox"/> Not known		Diagnosis:					
Patient informed of diagnosis: <input type="checkbox"/> Yes <input type="checkbox"/> No		Date of surgery/biopsy (D/M/Y): <input type="checkbox"/> N/A					
Site: <input type="checkbox"/> Breast <input type="checkbox"/> Lung <input type="checkbox"/> G.I.		<input type="checkbox"/> Haematology <input type="checkbox"/> G.U. <input type="checkbox"/> Gynaecology		<input type="checkbox"/> Melanoma <input type="checkbox"/> Unknown primary <input type="checkbox"/> Other (specify)			
Referral Type: <input type="checkbox"/> Standard <input type="checkbox"/> Urgent <input type="checkbox"/> Emergency		Specific Oncologist: <input type="checkbox"/> No <input type="checkbox"/> Yes (specify) _____					
NOTE: This patient remains under the care of the referring physician until seen and accepted by an Oncologist							
REMINDER: Please send the following, if available:							
REPORTS:				DIAGNOSTIC IMAGING:			
	Faxed	With patient	On Meditech		Faxed	With patient	On Meditech
Referral letter/H&P	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chest x-ray	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Operative/Bronchoscopy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other plain films	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pathology reports	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ultrasound	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
X-ray report	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bone scan	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	CAT scan	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Previous cancer Tx records if available	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mammogram	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Receptors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				MRI	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Referring physician signature: _____							
OFFICE USE ONLY – TO BE COMPLETED BY ONCOLOGY CLINIC STAFF (Fax back to referring physician)							
New patient consultation <input type="checkbox"/>		Date & Time _____					
Patient/SDM notified of appointment <input type="checkbox"/>		Oncologist: _____					
Triaged by (signature): _____		Date notified: _____		Pt needs to be seen in: <input type="checkbox"/> < 1 week <input type="checkbox"/> 1-2 weeks <input type="checkbox"/> > 2 weeks			
				Date: _____			