

**Oncology Patient Navigation Program (OPNP) Referral Form**

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|  **TEL: (519) 685-8500 ext: 53232 FAX: (519) 432-1805** |
| **PATIENT INFORMATION** | Date of Referral: |
| **First Name:** | **Last Name:** | Date of Birth: |
| Address: | Apt. #: | City, Town, Village: |
| Postal Code: | Phone Number: | OHIP: |
| Translator Required: [ ]  **Yes** [ ]  **No**SpecifyLanguage**:** | **Is patient aware of referral?** [ ]  **Yes** [ ]  **No****Is the patient aware of potential cancer diagnosis?** [ ]  **Yes** [ ]  **No** |
| **Please select area of concern:**[ ]  **Anal**  [ ] **Lung** [ ]  **Rectal**  |
| **For lung referrals please provide most recent CT thorax report.** |
| Reason for referral/pertinent presenting symptoms:  |
| Significant past medical history: *(Can attach Cumulative Patient Profile)* |
| Recent related diagnostic tests:  |
| **FAX WITH REFERRAL FORM**[ ]  Pertinent imaging reports [ ]  Blood work results within last 3 months ***(including. chest x-ray, CT chest scan) (including CBC, INR/PTT, Urea, Creatinine, Electrolytes)***[ ]  Current list of medication [ ]  Pathology /cytology results (if available) |
| **REFERRING PHYSICIAN**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Physician Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **FAMILY PHYSICIAN *(if not referring physician)***Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **PLEASE INFORM ALL PATIENTS OF REFERRAL. OPNP WILL CONTACT PATIENT DIRECTLY WITH APPOINTMENT.****NOTE: An incomplete referral form may lead to delays in appointment booking.** |