



CANCER PROGRAM REFERRAL

Help us speed up your patient's journey:

Step 1: Ensure the minimum referral criteria is met (See Referral Guide CLN 114 A for the disease site you check off in the table below).

Step 2: Fax your completed form and the minimum referral clinical information to The Ottawa Hospital's Cancer Program's Intake Office according section C below.

Patients will be notified of receipt of referral within 14 days.

A PATIENT INFORMATION (ALL fields mandatory)

Please affix label or plaque above if necessary.

Last name		First name		Middle name		Init.	Previous last name	
Date of Birth	Provincial Insurance no.		Version	Expiry Date	Gender <input type="checkbox"/> F <input type="checkbox"/> M		TOH MRN (if applicable)	
Address			City	Postal code	Home phone		Other phone	
Alternate contact			Relationship		Home phone		Other phone	
Preferred Language <input type="checkbox"/> English <input type="checkbox"/> French <input type="checkbox"/> Other:					<input type="checkbox"/> Translator:			
Special Needs: <input type="checkbox"/> None <input type="checkbox"/> Wheelchair <input type="checkbox"/> Portable Oxygen			Patient arriving from: <input type="checkbox"/> Home <input type="checkbox"/> Hospital <input type="checkbox"/> Nursing Home/Long Term Care <input type="checkbox"/> Arriving by ambulance <input type="checkbox"/> Other:					

Confirmation that this patient has been informed of being referred to the Cancer Program
 If diagnosed, confirmation this patient has been notified of diagnosis

TRANSFER OF CARE from:

B Clinical Information/Reason for Referral: Consult for suspicion of cancer Consult for diagnosed cancer

Biopsy performed? No Yes (date & attached following report): _____

C The Ottawa Hospital's Cancer Program's Intake Offices

Breast (Women's Breast Health Centre): F: 613-761-4994 P: 613-761-4400

Thoracic (lung, esophageal, gastric): F: 613-737-8643 P: 613-737-8501

Gynecology Oncology

F: 613-738-8230 P: 613-738-8400 ext. 81746

HPB (Hepato-Pancreato-Biliary) Oncology

F: 613-739-6854 P: 613-739-6979

Urologic Oncology (bladder, kidney, testes)

F: 613-739-6678 P: 613-737-8899 ext.71203

Surgical Assessment

Colorectal F: 613-737-8643 P: 613-737-8501

Prostate F: 613-737-8643 P: 613-737-8501

Direct to Radiation Oncology and/or Medical Oncology (A confirmed malignancy from a pathology report is required): F: 613-247-3516 P: 613-247-3525

Breast: <input type="checkbox"/> Invasive	<input type="checkbox"/> Locally advanced	<input type="checkbox"/> Central Nervous System (CNS)	<input type="checkbox"/> Gastrointestinal (GI)	<input type="checkbox"/> Genitourinary (GU)
<input type="checkbox"/> DCIS	<input type="checkbox"/> Inflammatory	<input type="checkbox"/> Dermatology/Melanoma	<input type="checkbox"/> Sarcoma	<input type="checkbox"/> Endocrine
		<input type="checkbox"/> Lymphoma (Rad Onc)	<input type="checkbox"/> Head & neck	<input type="checkbox"/> Unknown primary

D Pending Test Results (see Referral Guide CLN 114 A for details) Additional documents included with referral

Please attach all pertinent documents and list any pending tests in the table below:

TEST	DATE	LOCATION (if not TOH)	TEST	DATE	LOCATION (if not TOH)

E PHYSICIAN INFORMATION

Family Physician

Referring physician same as family physician

Referring Physician (printed name)

Signature

Date

Phone Number

Billing Number