Reset Form

Trillium Health Partners

mississauga halton /central west regional cancer program
in partnership with cancer care ontario

Mississauga Halton / Central West Regional Cancer Program

PATIENT REFERRAL FORM

Please include pathology, operative and consult reports.
Also include any recent imaging reports.

Telephone - 1-877-813-4150 **Fax - 905-813-4168**

CVH U#: _____

Patient's Surname: | Given Name:

Does patient require translator? If so, language? _____

Sex: ☐ Male ☐ Female D.O.B: _____ (DD/MM/YY)

Street (Apt) | City | Province | Postal Code

Home# | Work# | Health Card Number: | Version Code

Patient Location: ☐ **Home** ☐ **Hospital** _____
Hospital / Inpatient Unit / Unit Extension

Referring Physician Name:	Physician Number:	Telephone #:	Fax #:	Alternate Patient Contact: Name:
Family Physician Name:	Physician Number:	Telephone #:	Fax #:	Phone #:

Choose Requested Service(s):

- ☐ Medical Oncology
- ☐ Radiation Oncology
- ☐ Gyne Oncology
- ☐ Surgical Oncology
- ☐ Brachytherapy

CHOOSE PRIMARY SITE:

- ☐ Breast
- ☐ Gyn
- ☐ Melanoma
- ☐ Haematologic
- ☐ CNS
- ☐ Head & Neck
- ☐ Skin (Non-Melanoma)
- ☐ Other (Specify):
- ☐ G.I.
- ☐ Lung
- ☐ Unknown Primary
- ☐ G.U.
- ☐ Lymphoma
- ☐ Prostate

Reason for Referral
(PLEASE ENSURE PATIENT IS AWARE OF REASON FOR REFERRAL)

☐ New ☐ 2nd Opinion
☐ Recurrent/Progressive

Previous Radiation? ☐ Yes Please provide previous radiation records with referral

Body Site _____

INVESTIGATIONS BOOKED: Include Date & Testing Facility

Please include referral letter, pathology report(s), operative report(s), blood work results (if applicable) and ALL radiology reports that pertain to the referred patients diagnosis. ANY missing information/reports WILL delay the processing of this referral.

_____ _____
Signature of Referring Physician (Mandatory) **Date**

FOR OFFICE USE ONLY

Date Received: _____ (DD/MM/YY)

☐ Appointment: Date: _____ Time: _____ Physician: _____ Clinic: _____

☐ Other action: _____

Appointment Given to: ☐ Patient ☐ Referring MD on Date: _____ Initials: _____
☐ Other _____

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