REGIONAL CANCER PROGRAM REGIONAL PATIENT REFERRAL FORM

Mississauga Halton Central West Regional Cancer Program
in partnership with Cancer Care Ontario

****TRILLIUM HEALTH PARTNERS - QUEENSWAY HEALTH CENTRE, WILLIAM OSLER HEALTH SYSTEM & HALTON HEALTHCARE USE ONLY****

for referral to Regional Cancer Centre Radiation Program

Where would you like the appointment to take place?

☐ **Queensway Health Centre**	☐ **William Osler Health System**	☐ **Halton Healthcare**
150 Sherway Drive, Toronto, ON	*2100 Bovaird Dr E, Brampton, ON*	*3001 Hospital Gate, Oakville, ON*
Fax form to: 416-521-4104	**Fax form to: 905-813-3962**	**Fax form to: 905-338-4114**
Telephone: 416-521-4102	**Telephone: 905-813-1100 x4803/5115**	**Telephone: 905-813-1100 x4803/5115**

Patient's Surname: Given Name: **CVH U#:** _____

If patient does NOT speak English, please specify 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 #:

Family Physician Name: Physician Number: Telephone #: Fax #:

Alternate Patient Contact:
Name:
Phone #:

Requested Service(s):

☐ Medical Oncology
☐ Radiation Oncology
☐ Gyne Oncology
☐ Surgical Oncology**

PRIMARY SITE:

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

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 any outside reports not available in Credit Valley Hospital or Trillium Health Partners' Meditech systems. ANY missing information/reports MAY 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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