Erie St. Clair
Regional Cancer Program
in partnership with Cancer Care Ontario

INDIGENOUS PATIENT REFERRAL FORM

All information MUST be complete for the referral to be processed.
Incomplete or unsigned referrals will be returned for completion.

PATIENT INFORMATION (Please Print)

Surname	Given Name(s)	
Date of Birth ______/______/______ dd mm yy	Gender ❑ Male ❑ Female	OHIP # (Include Version Code)
Address	City/Province	Postal Code
Patient's Telephone Home ____________ Work ____________ Cell ____________	Contact Person Name ____________ Relationship ________ Home ____________ Work ____________ Cell ________	

CLINICAL INFORMATION

Other support agencies: ____________ ____________ Location: ______ ____________ ____________ Family Doctor: ____________ Telephone: ____________ Date of Interaction: ____________ Method of Interaction: ____________	Patient Informed of Reason for Referral? ❑ Yes ❑ No Date patient was informed: ____________ *Note: Patient **must** be informed of referral reason*	Reason for Referral ❑ Support Program ❑ Educational Program ❑ Diversional Program ❑ Volunteer Services ❑ Complementary Services

WINDSOR REGIONAL HOSPITAL – CANCER PROGRAM USAGE ONLY

Next of Kin
Name ____________ Relationship ____________
Address ____________ Postal Code ____________
Telephone (H) ____________ (W) ____________ (C) ____________

Family/Significant others

Name	Relationship	Phone #
____________	____________	____________
____________	____________	____________
____________	____________	____________

Fax Completed Forms to (519) 255-8670
ATTENTION: AUDREY LOGAN, Indigenous Navigator