WINDSOR REGIONAL HOSPITAL
OUTSTANDING CARE – NO EXCEPTIONS!

NEW PATIENT REFERRAL FORM

Cancer Program
Windsor Regional Hospital
1995 Lens Avenue
Windsor ON N8W 1L9

Please fax completed form to 519-253-5364

All below information is MANDATORY. Incomplete or unsigned referrals will be returned.

REFERRAL INFORMATION:

□ Patient has been informed of diagnosis **(We will not contact patient with appointment(s) unless □ is checked)**	Requested Services: □ Med Onc □ Rad Onc □ Palliative Care
Referral Type: □ Standard (2 weeks) □ Urgent (72 hours) □ Emergency (24 hours) (See referral guidelines on back for details)	Primary Site: □ Breast □ CNS □ Endocrine □ G.I. □ Hempath □ G.U. □ Lung □ Skin □ Head&Neck □ Gyne □ Sarcoma Diagnosis:
Reason for Consultation: □ New Diagnosis □ Recurrent/progressive disease □ Second opinion Comments: _____	Have you consulted with Oncologist? □ Yes □ No Name: _____ Date : _____ Patient Location: □ Home □ In- Patient Facility: _____

NOTE: This patient remains under the care of the referring physician until seen by an oncologist at WRCC.

PATIENT INFORMATION/DEMOGRAPHICS (please print)

Surname:	Given Name(s):
Date of Birth: Gender: □ M □ F _____/_____/_____ DD MM YY	OHIP # (including version code) or non-OHIN information:
Address:	Home: _____ Cell: _____ Work: _____ Email: _____
Alternate Contact Person: _____ Relationship: _____ Phone: _____	Preferred Language: □ ENG □ FR □ Other: _____ □ Translator Needed: _____ Special Needs: □ Wheelchair □ Portable Oxygen
Family Physician: _____ Fax: _____ Phone: _____	

CLINICAL INFORMATION

□ Patient is Palliative □ Patient is Ambulatory □ Patient is Clinically Stable □ Patient has MRSA □ Patient has *C. Difficile* □ Patient has VRE	Date of Last Surgery: _____ Further surgery planned? □ Yes □ No Do you want patient seen prior to surgery? □ Yes □ No	Previous Cancer Treatment? □ Yes □ No □ Chemotherapy □ Radiation □ Other: Facility: _____ Date: _____ Disease Site: _____
	Has the patient used tobacco products in the last 6 months? □ Yes □ No □ Unknown Is patient currently being followed within a DAP? □ Yes □ No Was patient reviewed at a Multidisciplinary Cancer Conference (MCC)? □ Yes □ No Outcome/Treatment recommendation: _____	

CLINICAL NOTES

<u>Please attach consult and most recent follow-up notes- see reverse for further report requirements.</u>

Registration without confirmed pathology cannot occur without Oncologist approval. If you need to speak with an Oncologist, please phone 519-255-6757.

Please send ORIGINAL documents. Please DO NOT combine reports.

Referring Physician Name: _____	Signature: _____
OHIP Billing Number: _____	Date: _____
Phone: _____	Fax: _____

NEW PATIENT REFERRAL FORM

It is expected that the patient has been informed of their diagnosis of cancer prior to their referral. WRCC clerical staff contacts new patients by telephone a few days after the referral is made to provide further information about their first appointment. This may cause undue stress for newly diagnosed patients if they are unaware of their diagnosis.

Definitions: Referral Types

Standard Referral:	Seen within 2 weeks of referral	Patients requiring consultation with a Medical or Radiation Oncologist for consideration of treatment options
Urgent Referral:	Seen within 72 hours from time of referral	**Please call to discuss with the WRCP attending Oncologist.** Patients who require immediate chemotherapy or radiation therapy to avoid potential oncological emergencies
Emergency Referral:	Seen within 24 hours	**Please call to discuss with the WRCP attending Oncologist.** Patients requiring immediate chemotherapy or radiation therapy for a life threatening oncological emergency

Report Requirements: please attach to referral according to patient diagnosis

Breast

- Operating notes
- Pathology
- Biopsy and definitive surgery reports
- Estrogen/progesterone receptor results
- Imaging

Additional Tests For:
Invasive, locally advanced or inflammatory cancer

- Bone scan, abdominal/pelvis ultrasound, CT and chest X-ray

Bone Marrow Transplant

- Skeletal survey
- Bone scan
- CT
- Bone marrow biopsy

CNS

- CT
- MRI
- Pathology

Gastrointestinal

- Pathology
- Operating notes
- CT and/or abdominal ultrasound
- Blood work
- CEA, CA 19-9
- Esophagus: PET
- GE Junction: MRI
- Rectal: MRI

Genito-Urinary

- Pathology
- Operating notes
- TRUS
- CT abdomen/pelvis, bone scan
- Prostate: last 3 PSAs, Gleason >7
- Testicular: AFP & BHCG

Gynecology

- Last pap test
- Operating notes
- Pathology
- Ultrasound
- Blood work
- CA125 results

Haematology

- Last 3 labs

Head and Neck

- Operating notes
- Pathology
- CT head and neck
- Biopsy

Lung

- Pathology: if positive tissue diagnosis not established - refer to thoracic surgeon
- Operating notes
- CT chest, head
- Pulmonary function

Lymphedema/Hot Flash

- Clinic notes
- If new – all records related to cancer

Lymphoma

- Pathology
- Operating notes
- CT chest/abdomen/pelvis

Melanoma

- Pathology
- Operative notes

Myeloma

- Skeletal survey
- Bone scan
- CT
- Bone marrow biopsy
- Blood work

Neuroendocrine

- Pathology
- Operating notes
- KI67
- Mytotic count
- Octreotide scan
- CT

Palliative & Pain

Recent consult note indicating reason for referral

Sarcoma

- Pathology
- Operating notes
- MRI, CT

Skin

- Pathology
- Biopsy