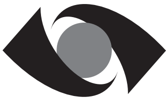

SOUTHLAKE
REGIONAL HEALTH CENTRE

596 Davis Drive
Newmarket, ON L3Y 2P9

Stronach Regional Cancer Centre

Health Record #: ____________ Complete or place barcoded patient label here

Patient Name: *(Print first, last)* ____________

DOB: dd / mm / yy Age: ______ ❑ Female ❑ Male

OHIP #: ____________ Version Code: ____________

Account #: ____________ Date of Admission: dd / mm / yy

Inpatient SRCC Referral Form - FAX TO: 905-952-2820

Ward:	**Ext.**	**Room:**
Service Requested: ❑ Radiation Oncology		
Diagnosis:		
Reason for Referral:		
Urgency to Assessment: ❑ Urgent *(less than 3 days)*. ❑ Emergent *(less than 24 hours)*. **Must page the Radiation Oncologist or call ext. 2216.**		
FOR QUERIES PLEASE CALL (905) 895-4521, ext. 6600		
Referring Physician Name: *(print first, last)*	**Billing #:**	
Signature :		
Form Completed by: *(print first, last)*	**Designation:**	
Signature:	**Date:** dd / mm / yy	

S-SRCCIR

SL0580_07 (02/15) “Stronach Regional Cancer Centre” Review (02/18)