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

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

Please review and complete **ALL** the required information and fax to (905) 952-2820. Lack of information **MAY DELAY** appointment scheduling.

Patient's Name: *(print first, last)*	**Date of Birth:** dd / mm / yy
Address: Street Number and Name Apartment City Province Postal Code	
Health Card #:	**Version Code:**

List home phone number and, if applicable, one alternate number. For each number, use the tick boxes to indicate consent to be called at that number and/or if messages relating to care and appointments can be left at that number:

Home: ( )	❑ Can call at this number	❑ OK to leave a message
Work/Other: ( )	❑ Can call at this number	❑ OK to leave a message

Alternate Contact Person: *(print first, last)*	**Relationship:**
Home: ( )	**Work/Other:** ( )
Family Doctor: *(print first, last)*	
Phone: ( )	**Fax:** ( )

Referral Date: dd / mm / yy

Please indicate the service requested: ❑ Medical Oncology ❑ Radiation Oncology

Diagnosis:

Patient aware of diagnosis: ❑ Yes ❑ No

Urgency to Assessment:
- ❑ Routine *(less than 14 days)*
- ❑ Urgent *(less than 7 days)*. **Explanation:** _____
- ❑ Emergent *(less than 24 hours)*. *Page the appropriate on call oncologist.*

Reason for Consultation: ❑ New Diagnosis ❑ Recurrent/Progressive ❑ 2nd Opinion

Details: _____

Recent Imaging Relevant to Diagnosis: If Pending: Date and Location of test booked

❑ CT	_____	❑ MRI	_____
❑ Mammogram	_____	❑ Ultrasound	_____
❑ Bone Scan	_____	❑ X-ray	_____
❑ _____	_____	❑ _____	_____

***Please include available reports and ensure patient brings images on CD**

Please include the following:

Brief History:	❑ Included	❑ Pending	Most recent consult note:	❑ Included	❑ Pending
Recent Pathology:	❑ Included	❑ Pending	Previous Pathology:	❑ Included	❑ Pending
Medication List:	❑ Included	❑ Pending	Recent Lab Reports:	❑ Included	❑ Pending
Operative Report:	❑ Included	❑ Pending	_____:	❑ Included	❑ Pending

FOR QUERIES PLEASE CALL (905) 830-5800

Referring Physician Name: *(print first, last)*	**Billing #:**
Signature:	**Date:** _____/_____/_____
Phone Number: ( )	**Fax Number:** ( )