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

Adult Benign Hematology and Thrombosis Clinic Referral Form - FAX TO: 905-853-2217

Please review and complete **ALL** the required information and fax to (905) 853-2217. 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

Reason for Consultation: ____________

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) 895-895-4521 ext.6269

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

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