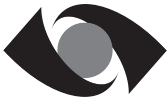

SOUTHLAKE
REGIONAL HEALTH CENTRE

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). Must speak directly to the appropriate oncologist - Call: 905-895-4521, ext. 6600.*

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) 895-4521, ext. 6600

Referring Physician Name: *(print first, last)* **Billing #:**

Signature: **Date:** ____/____/____

Phone Number: ( ) **Fax Number:** ( )