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 Psychosocial Oncology & Palliative Care Referral Form *Fax to: 905-952-3050*

PLEASE INCLUDE RELEVANT CONSULT NOTES AND INVESTIGATIONS

Date of Referral: dd / mm / yy

Patient Location: *(institution)* | **Date of Appointment:** dd / mm / yy *(clinic use only)*

Patient Name: *(print first, last)*

Address: | **Phone #:** ❑ Preferred

Alternate Contact Name: *(print first, last)*

Relationship: | **Alternate Contact Phone #:**

Primary Care Physician Name: *(print first, last)*

Referral to: ❑ Psychosocial Assessment Clinic ❑ Pain and Symptom Management Clinic

REASON FOR REFERRAL: ❑ Urgent

_____

_____

CANCER - Primary Site: _____

Cancer Metastases: *(check all that are known)* ❑ Bone ❑ Brain ❑ Liver ❑ Lung ❑ Other: *(specify)* _____

Comments: _____

_____

_____

_____

SYMPTOMS PRESENTING: *(Include ESAS Scores from last visit)*

Pain ___ **/10** Fatigue ___ **/10** Nausea ___ **/10** Depression ___ **/10** Anxiety ___ **/10** Anorexia ___ **/10**

Shortness of Breath ___ **/10** Constipation ___ **/10** Other _____ ___ **/10**

Performance Score: Palliative Performance Scale (PPS) _____ ***OR*** Eastern Cooperative Oncology Group (ECOG) _____

BY SIGNING THIS FORM, I CONFIRM THAT THIS PATIENT IS AWARE OF THIS REFERRAL

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

Referring Physician Signature: | **Date:** dd / mm / yy

Phone Number: | **Fax Number:**