SOUTHLAKE
REGIONAL HEALTH CENTRE

596 Davis Drive
Newmarket, Ontario
L3Y 2P9

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Fax. (905) 830-5966
Website: www.southlakeregional.org

Stronach Regional Cancer Centre Incomplete Patient Referral Return Form

Date: dd/mm/yy	**Total # of Pages:**
Referring Physician Name: *(print first, last)*	
Telephone Number: (905) 895-4521 EXT. 6600	**Fax Number:** (905) 952-2820
Patient Name: *(print first, last)*	
Patient D.O.B: dd/mm/yy	**Health Card Number:**

We will require the following information to be able to process your recent request for consultation and determine clinical urgency. Please fax the required information as soon as possible or let us know if the information is unavailable.

Your request is being returned for the following reasons:

- ❑ Complete new patient SRCC referral form
- ❑ Contact number and alternate contact number
- ❑ Diagnosis or clinical reason for referral
- ❑ X-ray, U/S, CT, MRI, PET scan, Mammogram, Bone scan report(s)
- ❑ Date/place of scheduled diagnostic bookings _____
- ❑ Most recent consult note _____
- ❑ Recent Lab reports _____
- ❑ Recent Pathology or previous pathology _____
- ❑ Operative report _____
- ❑ Other _____

Note: _____

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Please fax the requested information to (905) 952-2820.