



# CANCER PROGRAM REFERRAL

**Help us speed up your patient's journey:**

**Step 1:** Ensure the minimum referral criteria is met (See Referral Guide CLN 114 A for the disease site you check off in the table below).

**Step 2:** Fax your completed form and the minimum referral clinical information to The Ottawa Hospital's Cancer Program's Intake Office according to section C below.

**Patients will be notified of receipt of referral within 14 days.**

**A) PATIENT INFORMATION (ALL fields mandatory)**

Please affix label or plaque above if necessary

Last name		First name		Middle name	Init.	Previous last name	
Date of Birth		Provincial Insurance no.		Version	Expiry Date	Gender	TOH MRN (if applicable)
						<input type="checkbox"/> F <input type="checkbox"/> M	
Address			City	Postal Code	Home phone	Other phone	
Alternate contact			Relationship		Home phone	Other phone	
Preferred Language: <input type="checkbox"/> English <input type="checkbox"/> French <input type="checkbox"/> Other:				Translator needed: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, specify language:			
Special Needs: <input type="checkbox"/> None <input type="checkbox"/> Wheelchair <input type="checkbox"/> Portable Oxygen				Patient arriving from: <input type="checkbox"/> Home <input type="checkbox"/> Hospital <input type="checkbox"/> Nursing Home/Long Term Care Arriving by: <input type="checkbox"/> Ambulance <input type="checkbox"/> Other:			
<input type="checkbox"/> Confirmation that this patient has been informed of being referred to the Cancer Program					<b>TRANSFER OF CARE</b> from:		
<input type="checkbox"/> If diagnosed, confirmation this patient has been notified of diagnosis							

**B) Clinical Information/Reason for Referral:**  Consult for suspicion of cancer  Consult for diagnosed cancer

Biopsy performed?  No  Yes (date & attached following report): \_\_\_\_\_

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**C) The Ottawa Hospital's Cancer Program's Intake Offices (Surgical Assessment)**

<input type="checkbox"/> <b>Breast (Breast Health Centre):</b> F: 613-761-4994 T: 613-761-4400	<input type="checkbox"/> <b>Head and Neck</b> F: 613-739-6851 T: 613-737-8899 ext. 75076
<input type="checkbox"/> <b>Thoracic (lung, esophageal, gastro-esophageal junction)</b> F: 613-737-8643 T: 613-737-8501	<input type="checkbox"/> <b>Orthopedic Oncology:</b> F: 613-737-8150 T: 613-737-8213
<input type="checkbox"/> <b>Colorectal</b> F: 613-737-8643 T: 613-737-8501	<input type="checkbox"/> <b>Gynecology Oncology:</b> F: 613-738-8230 T: 613-738-8400 ext. 81746
<input type="checkbox"/> <b>Prostate</b> F: 613-737-8643 T: 613-737-8501	<input type="checkbox"/> <b>Urologic Oncology (bladder, kidney, testes):</b> F: 613-739-6678 T: 613-737-8899 ext. 71203
<input type="checkbox"/> <b>HPB (Hepato-Pancreato-Biliary) Oncology:</b> F: 613-739-6854 T: 613-739-6979	<input type="checkbox"/> <b>Malignant Hematology (Lymphoma, Multiple Myeloma, Leukemia):</b> F: 613-737-8861 T: 613-737-8899 ext. 72444
<input type="checkbox"/> <b>General Surgical Oncology (Gastric, GIST, Sarcoma, Melanoma, GI Carcinoids, Abdominal Masses NYD)</b> F: 613-737-8659 T: 613-737-8899 ext. 71619	

**Direct to Radiation Oncology and/or Medical Oncology** (A confirmed malignancy from a pathology report is required): F: 613-247-3516 T: 613-247-3525

Breast: <input type="checkbox"/> Invasive <input type="checkbox"/> Locally advanced <input type="checkbox"/> DCIS <input type="checkbox"/> Inflammatory	<input type="checkbox"/> Central Nervous System (CNS) <input type="checkbox"/> Dermatology/Melanoma <input type="checkbox"/> Lymphoma (Rad Onc) <input type="checkbox"/> Rapid Palliative	<input type="checkbox"/> Gastrointestinal (GI) <input type="checkbox"/> Sarcoma <input type="checkbox"/> Head & neck	<input type="checkbox"/> Genitourinary (GU) <input type="checkbox"/> Endocrine <input type="checkbox"/> Unknown primary
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**D) PHYSICIAN INFORMATION** Family Physician  Referring physician same as family physician

Referring Physician (printed name)	Signature	Date	Phone Number	Fax Number	Billing Number
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