

**PEEL REGIONAL CANCER PROGRAM
TRANSFER OF REFERRAL FORM**

Telephone - 1-877-813-4150 ■ Fax - 1-888-813-4168

Patient's Surname:	Given Name:
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Does Patient Speak English? Yes No _____
specify
Sex: Male Female D.O.B: _____ (DD/MM/YY)

Street (Apt) _____ City _____ Province _____ Postal Code _____

Home# _____ Work# _____ Health Card Number: _____ Version Code _____

Date Sent: _____ Patient Location: Home Hospital _____
(DD/ MM/ YY) Specify Hospital

Referring Physician Name: _____ Physician Number: _____ Telephone #: _____ Fax #: _____

Alternate Patient Contact:
Name: _____

Family Physician Name: _____ Physician Number: _____ Telephone #: _____ Fax #: _____

Phone #: _____

Requested Appointment Type

Clinic Visit Clinic Visit and Procedure Procedure Type _____

Clinic Visit with Systemic Treatment Protocol _____

Patient has central venous access device (CVAD) YES NO

Clinic visit with transfusion Platelets Packed Red Cells

Laboratory Testing Required at PRCC

Routine Blood (CC-MED) including CBC, Lytes (sodium, potassium, chloride, total CO₂), urea, creatinine, random glucose, AST, ALK Phos, LD, Bili unconjugated, Bili conjugated, albumin, calcium, magnesium)

Pending Hemoglobin CC-Hep (includes Anti-Hbc, Hbsag, Hepatitis C)
(order set)

Serum Protein Electrophoresis

Other _____

