

**PEEL REGIONAL CANCER PROGRAM
REGIONAL PATIENT REFERRAL FORM**

- Credit Valley Campus Trillium Campus
 Halton Health Campus William Osler Campus

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

Patient's Surname: _____ Given Name: _____

If patient does NOT speak English, please specify language _____

Sex: Male Female D.O.B: _____ (DD/MM/YY)

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

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

Patient Location: Home Hospital _____
Hospital / Inpatient Unit / Unit Extension _____

Referring Physician Name: _____ Physician Number: _____ Telephone #: _____ Fax #: _____
Alternate Patient Contact: Name: _____

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

- Requested Service(s):** **PRIMARY SITE:**
- Medical Oncology Breast CNS G.I. G.U.
 Radiation Oncology Gyn Head & Neck Lung Lymphoma
 Gyne Oncology Melanoma Skin (Non-Melanoma) Unknown Primary
 Surgical Oncology** Haematologic Other (Specify): _____

** Please fax Thoracic Referrals to 1-877-530-4425

**Reason for Referral
(PLEASE ENSURE PATIENT IS AWARE OF REASON FOR REFERRAL)**

- New 2nd Opinion Previous Radiation? Yes Please provide previous radiation records with referral
 Recurrent/Progressive Body Site _____

INVESTIGATIONS BOOKED: Include Date & Testing Facility

Please include referral letter, pathology report(s), operative report(s), blood work results (if applicable) and ALL radiology reports that pertain to the referred patients diagnosis. ANY missing information/reports WILL delay the processing of this referral.

Signature of Referring Physician (Mandatory) Date

FOR OFFICE USE ONLY

Date Received: _____
(DD/MM/YY)

Appointment: Date: _____ Time: _____ Physician: _____ Clinic: _____
 Other action: _____

Appointment Given to: Patient Referring MD on Date: _____ Initials: _____
 Other _____

