Markham Stouffville Hospital
Oak Valley Health

Pain & Symptom Management Referral

Cancer Centre

Fax: 905-472-7560
Phone: 905-472-7373 ext. 7068

PLEASE PRINT CLEARLY
OR AFFIX LABEL WITH COMPLETE INFORMATION

Patient Name (Last, First): ______________________________________

Telephone # (Best Daytime): ______________________________________

Date of Birth (DD/MM/YYYY): ______________________ Sex: F M

Health Card #: ___________________________ Version Code: _______

☐ WSIB # ____________________ ☐ Non OHIP (Self-pay) or Refugee

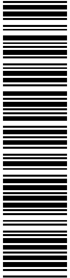
Urgency of Referral: ☐ 24hrs ☐ 1 Wk. ☐ 4 - 6 Wk.

Referral Date	**Referring MD**		**Signature**	**Telephone**
CPSO #	**BIlling #**	**Address**		**Fax**
Preferred Language		**Name & number of interpreter to help schedule appointment, if available**		

Chief Complaint:

Clinical History Relevant to Chief Complaint:

Allergies:



Significant Medical History Related to Chief Complaint:

Current Medications

Referrals ☐ SW ☐ Dietician