

NOTE: Incomplete and / or unsigned requisitions will be returned

PLEASE PRINT CLEARLY
OR AFFIX LABEL WITH COMPLETE INFORMATION



Markham Oncology Referral

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Please Fax To: 905-472-7046

Telephone: 905-472-7373 ext. 2029

Hospital MRN #: _____

Patient Name: _____

Date of Birth: _____ Sex: F M
Last First
Day Month Year

Health Card # _____ Version Code: _____

Address: _____ Postal Code: _____

WSIB # _____ Non OHIP (Self-pay) or Refugee

Telephone # (Best Daytime): _____

Alternate #: _____

- Emergent (less than 24 hours).**
Must speak directly to the on-call oncologist - Page the oncologist through locating
- Urgent (less than 7 days). Explanation: _____
- Routine (less than 14 days)

Referral Date (dd/mm/yyyy)		Referring MD	Telephone
CPSO #	Billing #	Address	Fax
Preferred Language		Name & number of interpreter to help schedule appointment, if available Please bring an interpreter to the appointment if required.	

Diagnosis:

Patient aware of diagnosis: Yes No

Reason for Referral: New Diagnosis Recurrent/Progression 2nd Opinion

Details: _____

For Breast Cancer Diagnosis:

Patients with Lumpectomy or LABC: Radiation Oncology Referral sent Date: _____

Recent Imaging Relevant to Diagnosis: If Pending, note date and location of test booked

- | | |
|--|---|
| <input type="checkbox"/> CT | <input type="checkbox"/> MRI |
| <input type="checkbox"/> Mammogram _____ | <input type="checkbox"/> Ultrasound _____ |
| <input type="checkbox"/> Bone Scan _____ | <input type="checkbox"/> X-ray _____ |
| <input type="checkbox"/> FDG-PET _____ | <input type="checkbox"/> Echo _____ |
| <input type="checkbox"/> Skeletal Survey (myeloma) _____ | <input type="checkbox"/> _____ |

Please include available reports and ensure patient brings images on CD

Please include the following:

- | | |
|--|--|
| Brief History: <input type="checkbox"/> Included <input type="checkbox"/> Pending | Most recent consult note: <input type="checkbox"/> Included <input type="checkbox"/> Pending |
| Recent Pathology: <input type="checkbox"/> Included <input type="checkbox"/> Pending | Previous Pathology: <input type="checkbox"/> Included <input type="checkbox"/> Pending |
| Medication List: <input type="checkbox"/> Included <input type="checkbox"/> Pending | Recent Lab Reports: <input type="checkbox"/> Included <input type="checkbox"/> Pending |
| Operative Report: <input type="checkbox"/> Included <input type="checkbox"/> Pending | _____ : <input type="checkbox"/> Included <input type="checkbox"/> Pending |

***** All external information MUST be faxed with this referral for appointment to be made *****

For office use only

Fax Complete: Yes No Date: _____ Appt Time: _____