London Health Sciences Centre
London Regional Cancer Program

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**London Regional Cancer Program**
790 Commissioners Road East
London, Ontario N6A 4L6

# NEW PATIENT REFERRAL

**All below information is MANDATORY. Incomplete or unsigned referrals will be returned**

**Please complete ALL information. Fax all related reports with this request (unless within Cerner)**

## PATIENT INFORMATION

Name:

Sex: ☐ Male ☐ Female

Date of Referral (YYYY/MM/DD):

Address:

Email Address:

Alternate contact:

Relationship:

Phone Number: ( )

LRCP/LHSC Chart Number:

Health Insurance Number:

Home/Cell Phone Number: ( )

Business Phone Number: ( )

Date of Birth (YYYY/MM/DD):

Patient Currently: ☐ Home ☐ Hospital
Name of Hospital:

Call Appointment to: ☐ Patient ☐ Physician ☐ Hospital

Patient Preference: ☐ Phone ☐ In Person ☐ Video ☐ No Preference

Has this patient used Tobacco products in the last 6 months? ☐ Yes ☐ No

NOTE: this patient remains under the care of the referring physician until seen by an oncologist at LRCP

## REFERRAL INFORMATION (To be completed by Referring Physician)

Referring Physician Name:

Billing Number:

Phone Number: ( )

Fax Number: ( )

Requested Services: ☐ **Med** Onc ☐ **Rad** Onc
☐ **Palliative** Care ☐ Nuclear Oncology

Priority: ☐ Urgent symptomatic ☐ Palliative Treatment
☐ Non Urgent

Primary Site: ☐ Breast ☐ Lung ☐ CNS ☐ Skin ☐ Endocrine
☐ Head & Neck ☐ G.I. ☐ Gyne ☐ Sarcoma ☐ G.U.
☐ Hematology ☐ Myeloma ☐ Leukemia ☐ Lymphoma
☐ BMT ☐ Pain

Patient Informed of Diagnosis: ☐ Yes ☐ No We will not contact patient with appointment(s) unless ☐ is checked
**"Patient not informed unless this is checked"**

Previous Cancer Treatment
☐ Yes ☐ No
Any Treatment Records
☐ Yes ☐ No

Chemotherapy:

Other:

Radiation Therapy:

Appointment Date and Time: ______________________________________________

History:

Date: ______________________ **Referring Physician Signature:** ______________________________________

## CLINICAL INFORMATION TO BE FAXED WITH REFERRAL

| | | ALL | MOST RECENT | CD TO BE SENT | TESTS BEING ORDERED (TO BE SENT WHEN COMPLETED/REPORTED |
|---|---|---|---|---|---|
| ☐ | Consult notes | | | | |
| ☐ | Operative notes | | | | |
| ☐ | CT Scans | | | | |
| ☐ | X-Rays | | | | |
| ☐ | Ultrasounds | | | | |
| ☐ | MRI | | | | |
| ☐ | Bone Scan | | | | |
| ☐ | Pathology | | | | |
| ☐ | Bloodwork | | | | |
| ☐ | Other | | | | |

## LRCP New Patient Referral Continued

| LRCP FOLLOW-UP (For LRCP Office Use Only) | |
|---|---|
| Clinic Appointment:<br><br>Given to:<br>☐ Patient ☐ Secretary<br>☐ Physician ☐ Other (state)<br>☐ Hospital | Doctor/Service Requested:<br><br>Reviewed By: ____________________<br>Physician Date Time |
| Appointment Cancelled by:<br><br>Rebooked Appointment: | Reason: |
| Information Taken By: | Booked: |