London Health Sciences Centre

Oncology Patient Navigation Program (OPNP) Referral Form

TEL: (519) 685-8500 ext: 56928 **Email: opnp@lhsc.on.ca** **FAX: (519) 432-1805**

PATIENT INFORMATION		Date of Referral:
First Name:	**Last Name**:	Date of Birth:
Address:	Apt. #:	City, Town, Village:
Postal Code:	Phone Number:	OHIP:
Patient Email Address:		

Translator Required: ☐ Yes ☐ No
Specify Language:

Is patient aware of referral? ☐ Yes ☐ No
Is the patient aware of potential cancer diagnosis? ☐ Yes ☐ No

Please select area of concern:

☐ Lung

☐ General Surgery

☐ Anal ☐ Colon ☐ Rectal (CLIPS) ☐ Liver ☐ Pancreas ☐ Biliary ☐ Other:

For colorectal referrals please provide endoscopy report and pathology (if available).
For lung referrals please provide most recent CT thorax report.
For liver/pancreas/biliary referrals please provide recent CT chest abdomen and pelvis.

Reason for referral/pertinent presenting symptoms:

Significant past medical history: *(Can attach Cumulative Patient Profile)*

Recent related diagnostic tests:

FAX WITH REFERRAL FORM

☐ Pertinent imaging reports
(including. chest x-ray, CT chest scan)

☐ Blood work results within last 3 months
(including CBC, INR/PTT, Urea, Creatine, Electrolytes)

☐ Current list of medication

☐ Pathology/cytology results (if available)

REFERRING PHYSICIAN

Name: ______________________________

Phone Number: ______________ Fax: ____________

Physician Signature: ______________________________

FAMILY PHYSICIAN ***(if not referring physician)***

Name: ______________________________

Phone Number: ______________________________

Fax: ______________________________

PLEASE INFORM ALL PATIENTS OF REFERRAL. OPNP WILL CONTACT PATIENT DIRECTLY WITH APPOINTMENT.

NOTE: An incomplete referral form may lead to delays in appointment booking.