Juravinski Cancer Centre
HAMILTON HEALTH SCIENCES

PATIENT REFERRAL FORM

Outpatient Oncology New Patient Referral
Juravinski Cancer Centre
699 Concession Street, Hamilton, ON, L8V 5C2
Please **COMPLETE ALL INFORMATION** and **FAX TO 905-575-6316 WITH ALL RELATED REPORTS**.
http://www.jcc.hhsc.ca/NPR

Please Print

Patient's Name:	M ○ F ○	Date of Birth (dd/mm/yy):
Health Card Number or non-OHIN information:	Version Code:	Language (if English not spoken):
Address:		
City:	Province:	Postal Code:
Phone (primary):	Phone (secondary):	

Patient Location: ○ Home ○ Institution _____
Institution/Inpatient Unit/Unit Extension

Alternate Contact:	Relationship:	Phone:
Referring Physician:	Fax:	Phone:
Family Physician:	Fax:	Phone:

NOTE: This patient remains under the care of the referring physician until seen by an Oncologist at JCC

Diagnosis:

Emergency/ Urgency: SVC Obstruction ☐ Cord Compression ☐ Bleeding ☐

Patient Informed of Diagnosis: ○ YES ○ NO

ARO Status: MRSA ☐ Pos VRE ☐ Pos ☐ Unknown

Requested Service(s):
☐ Medical Onc ☐ Surgical Onc
☐ Radiation Onc
☐ Supportive Care (reason below)

Reason: _____

Primary Site:
☐ Breast ☐ CNS ☐ G.I. ☐ G.U. ☐ Hematology
☐ Gyne ☐ Head & Neck ☐ Lung ☐ Sarcoma ☐ Autologous HSCT
☐ Melanoma ☐ Skin (Non-Melanoma) ☐ Genetics ☐ Allogenic HSCT

☐ Other (specify): _____

Reason for Consultation:
☐ New Diagnosis
☐ Recurrent/Progressive Disease
☐ 2nd Opinion
☐ Telemedicine Request

Comments:

Previous Cancer Treatment:
○ YES ○ NO Facility: _____

☐ Chemotherapy ☐ Radiation Other:

Investigations Scheduled (including Date & Testing facility):

_____
_____
_____
_____

Investigations Completed and Faxed / Available Electronically:

Reports:	Faxed	Clinical Connect	Radiology:	Faxed	OneView
Referral Letter/H&P	☐	☐	X-Ray	☐	☐
Operative/Scopes	☐	☐	Ultrasound	☐	☐
Pathology Reports	☐	☐	Bone Scan	☐	☐
Blood Work	☐	☐	CAT Scan	☐	☐
Pulmonary Functions	☐	☐	Mammogram	☐	☐
			Receptors	☐	☐
			MRI	☐	☐

NOTE: ANY missing information MAY DELAY the processing of this referral

_____ _____
Signature of referring physician (mandatory) **Date (dd/mm/yy)**

We will contact the referring physician with an appointment