Hamilton Health Sciences

Juravinski Cancer Centre

(Please contact the hematologist on call at 905-387-9495)

Acute Leukemia Referral

(Please fax completed referrals to 905-575-6316)

Date: (yyyy/mm/dd) _____

Patient's Last Name First Name

ID Number HIN Version Code

Patient's Birthdate (yyyy/mm/dd) Age Gender ☐ M ☐ F

PATIENT INFORMATION

Last Name:	Date of Birth: (yyyy/mm/dd)	
First Name:	Health Card #	Version Code:
Street Address:	City:	Province:
Phone (home)	(work)	(cell)
Next of Kin:	Relationship	Phone

Are Interpreter Services Required? ☐ No ☐ Yes → Language _____

PHYSICIAN INFORMATION

Referring Physician	Physician's Signature
Phone / Pager	Email
Fax	OHIP Billing Number
Family Physician	Family Physician Phone

PATIENT LOCATION AT TIME OF REFERRAL

☐ Hospital (specify): _____

☐ Home Unit/Clinic _____

☐ Other (specify): _____ Phone Number: _____

REASON FOR REFERRAL Is patient aware of diagnosis? ☐ Yes ☐ No

Diagnosis: ☐ Confirmed → ☐ Acute Myeloid Leukemia (AML) **or** ☐ Acute Lymphoblastic Leukemia (ALL)

☐ Presumptive

Note: The following information is needed at time of referral. If results are still pending, please indicate what testing you have sent specimens for and specify the laboratory processing the specimens.	**Sent**	**Pending**	**Laboratory processing the specimen**	**Date to Expect Results** (yyyy/mm/dd)
Admission note and/or consult note with complete history	☐	☐		
Routine hematology and biochemistry tests at diagnosis including trends if applicable.	☐	☐		
Relevant imaging and diagnostic reports	☐	☐		
Surgical procedures reports	☐	☐		
Cytogenetics, molecular, and FISH reports	☐	☐		
Pathology and flow cytometry reports (peripheral blood and/or bone marrow specimens and/or tissue biopsy)	☐	☐		

Upon receipt of referral form, and registration of patient, scan Referral form Immediately into MOSAIC