Trillium Health Partners
Better Together

Last Name: _____ First Name: _____

Date of Birth (DD/MM/YYYY): _____/_____/_____

Health card #: _____

MRN #: _____

CSN #: _____

THP use only

Affix patient encounter label here/complete all fields if label not available.

CARLO FIDANI REGIONAL CANCER CENTRE
PATIENT REFERRAL FORM

Telephone: 1-877-813-4150 **Fax – 905-813-4168**

Help us avoid delays in processing your patient's referral.
Step 1: Ensure the minimum referral information is provided (See below for **Cancer Program Referral Guide** for the disease site you requested in the table below).
Step 2: Fax your completed form and the required clinical information to the THP New Patient Registration Office **905-813-4168**
Your patient will be notified directly of their consult appointment once booked.

PATIENT DEMOGRAPHICS:

Last Name: _____ First Name: _____ Date of Birth (DD/MM/YYYY): _____/_____/_____

Health Card #: _____ Legal Sex: ☐ Female ☐ Male ☐ Non-Binary ☐ Unknown ☐ X

Address: _____ City: _____ Province: _____ Postal Code: _____

Telephone number: _____ Mobile number: _____ Email Address: _____

Alternate Contact: _____ Relationship: _____ Telephone Number: _____

Preferred Language: ☐ English ☐ French ☐ Other: _____ Translator Required: ☐ Yes ☐ No

Special Needs: ☐ None ☐ Wheelchair ☐ Portable Oxygen ☐ Other:_____

Patient arriving from: ☐ Home ☐ Hospital ☐ Nursing Home/ Long Term Care ☐ Arriving by ambulance ☐ Other:_____

CLINICAL INFORMATION:

Patient has been informed of their cancer diagnosis and this referral to the Cancer Program ☐ Yes ☐ No

Choose Requested Service
☐ Medical Oncology
☐ Radiation Oncology
☐ Gynecologic Oncology
☐ Surgical Oncology

Choose Primary Tumor Site:
☐ Breast ☐ Central Nervous System ☐ Gastrointestinal ☐ Genitourinary
☐ Gynecology ☐ Lung ☐ Lymphoma ☐ Prostate
☐ Melanoma ☐ Skin (Non-Melanoma) ☐ Haematology (Specify):_____
☐ Unknown Primary ☐ Other (Specify):_____
☐ Palliative Radiation

Previous Radiotherapy not delivered at THP/PRCC? ☐ Yes ☐ No *Please provide previous records with referral.* Body site: _____

Reason for Referral:
☐ New Diagnosis ☐ Recurrent Disease ☐ 2nd opinion ☐ Transfer of Care

_____

_____

_____

_____

_____

Please include referral form, pathology reports, and all other required information (see **Cancer Program Referral Guide** for the relevant disease site above (https://www.thp.ca/patientservices/CancerServices/for-professionals/Pages/Referral-Forms.aspx).
Incomplete referrals WILL delay processing and booking of consults.

REFERRING PROVIDER:

Name of Referring Provider (Last Name, First Name - as listed in CPSO): _____

Address: _____ City: _____ Province: _____ Postal Code: _____

Phone number: _____ Fax number: _____ CPSO #: _____ Billing (OHIP) #: _____

Signature: _____ Date: _____