Trillium Health Partners

www.trilliumhealthpartners.ca

PRCC Radiation Therapy
Treatment Record Request Form

Patient Information:		
Patient Name:		CVH ID:
Date of Birth:		
Health Card Number:		
Sending Information to:		
Hospital:	Radiation Oncologist:	
Date of Request: / /	Requested by:	
Required by Date: / /	Phone #:	Fax #:
Obtain Information from:		
Hospital: Credit Valley Hospital Recipient Name: Health Information Management Department Phone Number: (905) 813-4325 Fax Number: (905) 813-4101		
Information Requested:		
❑ Treatment Summary	❑ Planning Films (simulator, DDR)	
❑ Treatment Records	❑ Distribution	
❑ Others (please specify)		
Comments:		

Please note:

Requests are normally completed within 24 hours of receipt.
Requests received on weekends or holidays will be processed on the following business day.

HOSPITAL USE:

Date received: _____ HIM Staff: _____

Date completed: _____ Phone Number: _____

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Credit Valley Hospital
2200 Eglinton Avenue West
Mississauga ON L5M 2N1
T: (905) 813-2200

Mississauga Hospital
100 Queensway West
Mississauga ON L5B 1B8
T: (905) 848-7100

Queensway Health Centre
150 Sherway Drive
Toronto ON M9C 1A5
T: (416) 259-6671