Trillium Health Partners

mississauga halton /central west regional cancer program
in partnership with cancer care ontario

Peel Regional Cancer Program
Queensway Health Centre
150 Sherway Drive 2nd floor
Toronto, ON M9C 1A5
Tel: 416-521-4102
Fax: 416-521-4104

NEW PATIENT REFERRAL FORM

Patient' Surname:		Given Name:	
Sex: ☐ Male ☐ Female	DOB: (DD/MM/YY)	Health Card Number:	Hospital ID Number:
Street (Apt)	City	Province	Postal Code
Home Number:		Work Number:	
Referring Physician's Name:	Billing #:	Telephone Number:	Fax Number:
Family Physician's Name:	Billing #:	Telephone Number:	Fax Number:

Requested Service (s):

☐ Medical Oncology
☐ New ☐ Second Opinion
☐ Recurrent/Progressive

☐ Radiation Oncology
Previous Radiation? ☐ Yes Body Site: _________
Please provide previous radiation records with referral.

Is the patient aware of his/her diagnosis? ☐Yes ☐No **Is the pathology available? ☐Yes ☐No**

Reason for Referral:

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Please include referral letter, pathology report(s), operative report(s), blood work results (if applicable) and ALL radiology reports, **performed outside of Trillium Health Partners**, which pertain to the referred patient's diagnosis. ANY missing information/reports WILL delay the processing of this referral.

_________________________ _________________________
Signature of Referring Physician Date

FOR OFFICE USE ONLY

Appointment Date and Time:	Physician: