PEEL REGIONAL CANCER PROGRAM
TRANSFER OF REFERRAL FORM

Telephone - 1-877-813-4150 ▪ Fax - 905-813-4168

Patient's Surname: | Given Name:

Does Patient Speak English? ☐ Yes ☐ No _____ specify

Sex: ☐ Male ☐ Female D.O.B: _____ (DD/MM/YY)

Street (Apt) | City | Province | Postal Code

Home# | Work# | Health Card Number: | Version Code

Date Sent: _____ (DD/ MM/ YY) Patient Location: ☐ Home ☐ Hospital _____ Specify Hospital

Referring Physician Name: | Physician Number: | Telephone #: | Fax #:

Family Physician Name: | Physician Number: | Telephone #: | Fax #:

Alternate Patient Contact:
Name:

Phone #:

Requested Appointment Type

Clinic Visit ☐ Clinic Visit and Procedure ☐ Procedure Type _____

Clinic Visit with Systemic Treatment ☐ Protocol _____

Patient has central venous access device (CVAD) YES ☐ NO ☐

Clinic visit with transfusion ☐ Platelets ☐ Packed Red Cells ☐

Laboratory Testing Required at PRCC

Routine Blood (CC-MED) ☐ including CBC, Lytes (sodium, potassium, chloride, total CO2), urea, creatinine,random glucose, AST, ALK Phos, LD, Bili unconjugated, Bili conjugated, albumin, calcium, magnesium)

Pending Hemoglobin ☐

☐ CC-Hep (includes Anti-Hbc, Hbsag, Hepatitis C)
(order set)

Serum Protein Electrophoresis ☐

Other _____

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