REGIONAL CANCER PROGRAM REGIONAL PATIENT REFERRAL FORM

Mississauga Halton Central West Regional Cancer Program
in partnership with Cancer Care Ontario

****TRILLIUM HEALTH PARTNERS - QUEENSWAY HEALTH CENTRE, WILLIAM OSLER HEALTH SYSTEM & HALTON HEALTHCARE USE ONLY****

for referral to Peel Regional Cancer Centre Radiation Program

Where would you like the appointment to take place?

☐ **Queensway Health Centre**	☐ **William Osler Health System**	☐ **Halton Healthcare**
150 Sherway Drive, Toronto, ON	*2100 Bovaird Dr E, Brampton, ON*	*327 Reynolds St, Oakville*
Fax form to: 416-521-4104	**Fax form to: 905-813-3962**	**Fax form to: 905-813-3962**
Telephone: 416-521-4102	**Telephone: 905-813-1100 x 4803/5115**	**Telephone: 905-813-1100 x 4803/5115**

Patient's Surname: | Given Name:

CVH U#: ____________________

If patient does NOT speak English, please specify language ____________________

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

Street (Apt) | City | Province | Postal Code

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

Patient Location: ☐ Home ☐ Hospital ____________________
Hospital / Inpatient Unit / Unit Extension

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

Alternate Patient Contact:
Name:
Phone #:

Requested Service(s):
- ☐ Medical Oncology
- ☐ Radiation Oncology
- ☐ Gyne Oncology
- ☐ Surgical Oncology**

PRIMARY SITE:
- ☐ Breast
- ☐ Gyn
- ☐ Melanoma
- ☐ Haematologic
- ☐ CNS
- ☐ Head & Neck
- ☐ Skin (Non-Melanoma)
- ☐ Other (Specify):
- ☐ G.I.
- ☐ Lung
- ☐ Unknown Primary
- ☐ G.U.
- ☐ Lymphoma

Reason for Referral
(PLEASE ENSURE PATIENT IS AWARE OF REASON FOR REFERRAL)

- ☐ New
- ☐ Recurrent/Progressive
- ☐ 2nd Opinion

Previous Radiation? ☐ Yes — Please provide previous radiation records with referral

Body Site ____________________

INVESTIGATIONS BOOKED: Include Date & Testing Facility

Please include any outside reports not available in Credit Valley Hospital or Trillium Health Partners' Meditech systems. ANY missing information/reports MAY delay the processing of this referral.

____________________ ____________
Signature of Referring Physician (Mandatory) **Date**

FOR OFFICE USE ONLY

Date Received: ____________
(DD/MM/YY)

☐ Appointment: Date: ________ Time: ________ Physician: ________ Clinic: ________

☐ Other action: ____________________

Appointment Given to: ☐ Patient ☐ Referring MD on Date: ________ Initials: ________

☐ Other ____________________

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