CAMBRIDGE MEMORIAL HOSPITAL
700 Coronation Blvd.,
Cambrdige, ON N1R 3G2
519-621-2330

Cambridge Memorial Hospital Medical Day Care
Oncology Patient Referral Form Requirements

Referrals MUST be accompanied by:

- Pathology reports documenting a cancer diagnosis
- A consultation letter/note highlighting presenting signs, symptoms and findings
- Completed referral form - please inform patient of referral

Please note we do NOT treat sarcoma (other than GIST), primary CNS cancers, hematological cancers, head and neck cancers or gynecological cancers. Please refer to Grand River Regional Cancer Centre.

Our wish is to process referrals ASAP and to see patients within 2 weeks of receiving the referral. If tests/reports are in progress, please note the date of the procedure and the location on the referral form.

The following information and tests are required for staging and are important for patients to start on treatment as quickly as possible. Please order required testing in hopes the results will be available when patient is seen by the Oncologist.

	Breast	Gastrointestinal	Genitor-urinary	Lung
Lab Results	Stage 1 and DCIS no further labs Stage II - IV CBC/LFT's	CEA for colon cancer	Prostate: All PSA levels Testes: HCG, AFP, LDH (pre and post-op)	CBC, lytes, LFT's Creatinine
Pathology	Estrogen Progesterone and HER2 receptors	Pathology report Endoscopy report	Pathology report if done	Bronchoscopy report Pathology/OR reports
Diagnostic Imaging and other	Mammogram Stage 1 and DCIS no further D.I. Stage II with greater than 4 nodes Bone scan U/S abdo/liver and CXR or CT chest/abdo/ Pelvis Stage III and IV -bone scan -CT chest/abdo/ pelvis	CT Chest/abdo/pelvis MRI for rectal ca	Prostate: bone scan TRUS if done Testes: CXR CT abdo/pelvis Bladder: Cysto CT chest/abdo/pelvis Kidney: Bone scan CT Chest/abdo/pelvis	CT Chest/abdo/pelvis MRI brain PET (early stages) Pulmonary Function test

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Oncology/Palliative Care

Patient Referral Form

FAX: 519-740-7722

PATIENT INFORMATION (Complete form required. Incomplete forms WILL be returned)

Patient Name:	Date of Referral:
Address:	CMH Unit #: _____ Health Insurance #:
Date Of Birth: Home Telephone #:	Business/Other Telephone #:
Next of Kin:	Telephone Number #:
Patient Currently: Home: ❑ Hospital: ❑	Other:
Referring Physician: Telephone #:	Fax #:
Billing #:	
Family Physician: Telephone #:	Fax #:
Referral Disease Site:	
❑ Breast ❑ Gastrointestinal ❑ Lung ❑ Genitourinary ❑ Melanoma	
❑ Hepatobiliary/pancreatic ❑ Other:_____	
Service Requested: ❑ Medical Oncologist ❑ Radiation Oncologist	Is patient aware of their diagnosis ❑ Yes ❑ No
Newly Diagnosed:	Recurrent/Progressive Disease:

Procedures Relative To Condition

Operations/Procedures	Hospital	Date	Tissue #

Diagnostic Imaging

	Done		Location Completed	
	Yes	**No**		**Date**
Mammogram	❑	❑		
X-ray	❑	❑		
CT	❑	❑		
Ultrasound	❑	❑		
MRI	❑	❑		
Nuclear Medicine	❑	❑		
Laboratory Tests	❑	❑		

Signature of Referring Physician:_____ _____
(Physician) (Date)

TO BE COMPLETED BY CMH ONCOLOGY STAFF

Clinic Appointment Date:_____ Booked to:_____

Given to: Referring Physician ❑ Patient ❑ Hospital Staff ❑

Date:_____ Intake/Triage/Clerical Associate:_____