



Cancer Care Program Patient Referral

HCN: _____
Province/Territory: _____ Expiry: _____ / _____ / _____
Name: _____ First _____ Middle _____ Surname _____
Date of Birth: _____ / _____ / _____ Sex: ☐ M ☐ F ☐ UN
Mailing Address: _____
City: _____ Prov/Terr: _____ Postal Code: _____
Telephone: (Indicate Preferred) ☐ Home (____) - ____ - ____
☐ Cell (____) - ____ - ____ ☐ Work (____) - ____ - ____

Ordering Provider's Name: _____
Clinic Name: _____
Mailing Address: _____
City: _____ Prov/Terr: _____ Postal Code: _____
Phone: (____) - ____ - ____ Fax: (____) - ____ - ____
Ordering Provider's Meditech Mnemonic: _____
Signature: _____ Date: _____ / _____ / _____

Clinic Stamp: (include fax, provider and mnemonics)

EMR Clinic Mnemonic: _____

COPY TO PROVIDER _____

Family Physician (if not referring provider): _____

Next of Kin/Contact: _____ Phone: (____) - ____ - ____

Diagnosis: _____ Is the patient aware of the diagnosis? ☐ Yes ☐ No
Note: The Cancer Centre will only notify your patient of the date and time of their appointment if the patient is aware of their diagnosis.

Reason for Consultation:

☐ Newly Diagnosed ☐ Recurrent/Progressive Disease ☐ 2nd Opinion ☐ Palliative Radiation Oncology (PRO)

What is the patient's location? ☐ Hospital ☐ Home ☐ Other: _____

Does the patient require an interpreter? ☐ Yes ☐ No

If yes, for what language? _____

Does the patient have an infectious disease for which precautions need to be taken to protect staff and other patients? ☐ Yes ☐ No

If yes, what infectious disease? _____

Does the patient have any special needs? ☐ Wheelchair ☐ Stretcher ☐ Portable Oxygen

☐ Other: _____

Is referral to Cancer Patient Navigator required? ☐ Yes ☐ No

If yes, has patient been notified of referral? ☐ Yes ☐ No

Additional information is required when referring a patient to the Cancer Care Program. See **page 2** for a list of required tests to be completed (or ordered and in process) based on disease site.

Comments:

For **emergency cases**, please call 709-777-6300 and have the appropriate Oncologist, e.g., Medical, Radiation, or Gynecological Oncologist on call/consult paged.

Please complete and fax form to 709-777-8215. Lack of pertinent information may result in delays in scheduling a patient appointment. If you need to speak to the new patient registration clerical staff, please call 709-777-8214. or 777-6999.

R0015APR19

Cancer Care Program Patient Referral

REQUIRED FOR ALL DISEASE SITES (must be available in Electronic Record or included with referral)

Bloodwork: Cancer Clinic Profile (CCP)* for all sites *CCP includes CBC, Lytes, CR, total Bili, AST, ALT, ALP, Ca, GLU, MG, Albumin	Operative Reports X-Rays/Scans	History & Physical Discharge Summary	Consults Pathology
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<p style="text-align: center;">BREAST</p> <p>Reports: Breast Imaging reports; Bilateral Mammogram US, MRI (if done) Chest X-Ray ER (estrogen receptor)/PR (progesterone receptor) status HER 2 status (must be requested) Node Positive --As above plus: CT (chest, abdomen) Bone Scan</p> <p style="text-align: center;">Bloodwork: CCP</p>	<p style="text-align: center;">HEAD & NECK</p> <p>Reports: CT (head, neck) Chest X-Ray Tri-endoscopy</p> <p style="text-align: center;">Bloodwork: CCP</p>
<p style="text-align: center;">COLORECTAL</p> <p>Reports: Colonoscopy/Sigmoidoscopy CT (chest, abdomen, pelvis) Neoadjuvant Chemoradiotherapy: As above, plus MRI of pelvis</p> <p style="text-align: center;">Bloodwork: CCP CEA (pre & post Op)</p>	<p style="text-align: center;">BRAIN</p> <p>Reports: MRI - pre & post-op CT (brain)</p> <p style="text-align: center;">Bloodwork: CCP</p>
<p style="text-align: center;">PROSTATE</p> <p>Reports: TRUS with prostate volume High Risk Patient: As above plus: Bone Scan CT (chest, abdomen, pelvis)</p> <p style="text-align: center;">Bloodwork: CCP plus: Testosterone & PSA history (last 2 years PSA)</p>	<p style="text-align: center;">LUNG</p> <p>Reports: Chest X-Ray CT (chest, abdomen, pelvis) Mediastinoscopy report (if done) CT brain (if done) Bone Scan (if done) Pulmonary Function Tests (if done)</p> <p style="text-align: center;">Bloodwork: CCP</p>
<p style="text-align: center;">GASTRIC HEPATOBILARY</p> <p>Reports: Gastroscopy CT (chest, abdomen, pelvis)</p> <p style="text-align: center;">Bloodwork: CCP plus: -CA 19-9 for Pancreatic and Biliary -AFP for liver</p>	<p style="text-align: center;">BLADDER/KIDNEY</p> <p>Reports: CT (Chest, abdomen, pelvis) Urinalysis, Urine C&S Cystoscopy report</p> <p style="text-align: center;">Bloodwork: CCP</p>
<p style="text-align: center;">NEUROENDOCRINE TUMOUR</p> <p>Reports: Pathologic Diagnosis 24 hour urine 5-HIAA CT (chest, abdomen, pelvis) within past 3 months Octreotide Scan</p> <p style="text-align: center;">Bloodwork: CCP plus: Chromogranin A</p>	<p style="text-align: center;">TESTICULAR</p> <p>Reports: CT (chest, abdomen, pelvis) US of Scrotum</p> <p style="text-align: center;">Bloodwork: CCP plus: AFP, BHCG, LDH</p>
	<p style="text-align: center;">THYROID</p> <p>Reports: Iodine Scan US of Thyroid</p> <p style="text-align: center;">Bloodwork: CCP plus: TSH, T3, T4</p>
	<p style="text-align: center;">GYNECOLOGY</p> <p>Reports: Pap Test US or CT Reports MRI pelvis (for suspected cervical)</p> <p style="text-align: center;">Bloodwork: CCP plus: Ca-125 (for suspected ovarian cancer)</p>

Referral Criteria for PRO (Palliative Radiation Oncology)

All Patients:

- Biopsy proven solid malignancy
- Imaging available (within 3 months of referral)

Bone Mets Patients:

- Painful bone metastases, Post-operative bone metastases
- Imaging available: X-Ray +/- Bone Scan; other: CT, PET/CT, MRI
- No indication of spinal cord compression
- No indication of impending pathologic fracture

Brain Mets Patients:

- Imaging Available: CT brain +/- MRI
- Patient started on dexamethasone if symptomatic from brain metastasis.