niagarahealth
Extraordinary Caring. Every Person. Every Time.
Walker Family Cancer Centre

REFERRAL AND CONSULTATION FAX FORM

Outpatient Oncology New Patient Referral
St Catharines Site
1200 Fourth Avenue, St. Catharines, ON L2S 0A9
Phone: 905-684-7271 ext. 43804 Fax: 905-685-1201
ext. 43805

PATIENT INFORMATION

Patients Name:	Mr Mrs Ms Miss	Date of Birth:
Health Card Number:	Version:	Language:
Address:		
City:	Province:	Postal Code:
Phone: Home Cell:	Phone (work):	
Alternate Contact:	Relationship:	Phone:
Referring Physician:	Physician Number	Phone:
Family Physician:	Physician Number	Phone:

CLINICAL INFORMATION (Please include as much information as possible and FAX COPIES OF ALL REPORTS)

Diagnosis:	Patient Informed of Diagnosis ☐ YES ☐ NO	MRO Status ☐ MRSA ☐ VRE Other: ______

Reason for Consultation:

☐ New Diagnosis ☐ Recurrent/Progressive Disease ☐ 2nd Opinion Other:

Comments:

Previous Cancer Treatment: ☐ Chemotherapy Other:

☐ YES ☐ NO ☐ Radiation

Surgical Procedure:

Date: ______

☐ NHS

☐ Other: ______

	Included	Pending	Ordered	
X-Ray				
MRI				
CT				
Ultrasound				
Nuclear Med				
Other				

SPECIFY REQUESTED SERVICE

☐ Medical Oncology ☐ Radiation Oncology

FOR ONCOLOGY CLINIC USE ONLY

	Triage Information
Registration Date: ______ Referral (Ready to book) Date: ______ Consult Date: ______	

4/12/2017