Sunnybrook
ODETTE CANCER CENTRE
A Cancer Care Ontario Partner

Odette Cancer Centre
Fax-In Referral Form

Please FAX form and documents to
New Patient Booking Office: (416) 480-6179

Date of Referral (YYYY/MM/DD): _____

PATIENT IDENTIFICATION

Site: ☐ Breast ☐ Familial Breast ☐ G.U. ☐ Head & Neck ☐ Pigmented Lesion
☐ Breast Diagnostic ☐ Familial Melanoma ☐ Gynaecology ☐ Lung ☐ Skin
☐ CNS ☐ G.I. ☐ Haematology ☐ Melanoma ☐ Other (specify): _____

Specific ServiceRequired: ☐ Radiation Oncology ☐ Medical Oncology
☐ Surgical Oncology ☐ Breast Diag/Genetic Testing ☐ Second Opinion

Diagnosis: ☐ **Emergency/Urgent** (*within 48 hours*)

PATIENT INFORMATION:

Last Name:_____ First Name:_____

OHIP#:_____ Version Code:_____ DOB (D/M/Y):_____

Sex: ☐ Male ☐ Female ☐ _____ Does patient speak English? ☐ Yes ☐ No ☐ Other (specify):_____

Address:_____ City:_____ Postal Code:_____

Home Phone:_____ Business/Cell Phone:_____

Patient Location: ☐ Home ☐ Hospital (specify):_____

Other Contact Person Name and Phone Number:_____

DOCTOR INFORMATION:

Referring Physician:_____ Billing#:_____

Phone:_____ Ext._____ Direct Line:_____ Fax:_____

Family Physician:_____

Phone:_____ Ext._____ Direct Line:_____ Fax:_____

Surgeon:_____

Phone:_____ Ext._____ Direct Line:_____ Fax:_____

REFERRAL INFORMATION AND SUPPORTING DOCUMENTATION:

Patient Informed of Diagnosis? ☐ Yes ☐ No Date of surgery/biopsy (YYYY/MM/DD):_____ ☐ N/A

Specific OCC oncologist? ☐ No ☐ Yes (specify):_____

Treatment Setting: ☐ New ☐ Recurrent/Progressive ☐ Other:_____

Date of Previous anti-cancertreatments: ☐ Chemotherapy ☐ Hormonal Therapy ☐ Other (specify):_____

Date of Current anti-cancertreatments: ☐ Chemotherapy ☐ Hormonal Therapy ☐ Other (specify):_____

NOTE: This patient remains under the care of the referring physician until seen by an oncologistat OCC.

OCC OFFICE USE ONLY HFN Number:_____

Clinic Booked:_____ Date Booked:_____ Time Booked:_____

Clinic Booked:_____ Date Booked:_____ Time Booked:_____

Clinic appointment called to: ☐ Referring Physician ☐ Hospital ☐ Patient ☐ Other (specify): _____

Phone Number: (416) 480-4205
We will contact the referring doctor with an appointment.

REMINDER: Please send the following, if available:

Reports	Faxed	Pending
Referral Letter/H&P	☐	☐
Operative/Brochoscopy	☐	☐
Pathology Reports	☐	☐
X-Ray Reports	☐	☐
Chemo Schedules	☐	☐
Blood Work	☐	☐
Pulmonary Functions	☐	☐

Radiology Imaging	Faxed	Pending
Chest X-Ray	☐	☐
Other Plain Film	☐	☐
Ultrasound	☐	☐
Bone Scan	☐	☐
CAT Scan	☐	☐
Mammogram	☐	☐
Receptors	☐	☐
MRI	☐	☐

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