NEW PATIENT REFERRAL

Ph: 613-544-2631 ext. 4510
Toll free: 1-800-567-5722
Fax: 613-546-8214

PATIENT INFORMATION

Last Name	First Name	DOB (yyyy/mm/dd)	Sex ☐ F ☐ M ☐ Other	
OHIP/Version Code or Other Insurance	Address	City	Province	Postal Code
Home Telephone ( )	Work Telephone ( )	Extension	Mobile Telephone ( )	
Alternative Contact Person	Home Telephone	Work Telephone	Ext.	Mobile Telephone ( )
Primary Care Provider Name	Primary Care Provider Phone ( )	Primary Care Provider Fax ( )		
Referring Care Provider Name (Mandatory)	Referring Care Provider Signature	Date (yyyy/mm/dd)		
Referring Care Provider Telephone ( )	Ext.	Referring Care Provider Fax ( )	Referring Care Provider Email	

Is patient aware of referral? (mandatory) ☐ Yes ☐ No
If no, please advise patient *before* referring. **Patient must be aware of referral to oncology.**

Urgency for Assessment:

☐ Routine (Oncology patients will receive an appointment within 14 days)
☐ Urgent (Within 72 hours) - **Must speak directly with oncologist, call Switchboard at 613-549-6666 ext. 0 for on-call oncologist**
☐ Emergent (Within 24 hours) – **Must speak directly with oncologist, call Switchboard at 613-549-6666 ext. 0 for on-call oncologist**

REQUESTED SERVICE (Medical and Radiation Oncology only)

☐ Medical Oncology ☐ Radiation Oncology

This referral form is for medical and radiation oncology only.
Please refer to KGH website https://kingstonhsc.ca/programs-and-departments for other services.
Referral will be faxed back to referring doctor if not appropriate for medical or radiation oncology.

REFERRAL INFORMATION

Primary Site

☐ Breast ☐ CNS ☐ GI ☐ Gynecology ☐ Head and Neck
☐ Hematology ☐ Lung ☐ Lymphoma ☐ Sarcoma ☐ Skin
☐ Unknown Primary ☐ Other, specify: _____

For patients without a confirmed diagnosis, you may wish to consider referral to a Diagnostic Assessment Program (DAP).
Please see our DAP referral forms on our website: https://kingstonhsc.ca/healthcare-providers/cancer-centre-support-documents.

REASON FOR REFERRAL

CLINICAL INFORMATION (Please attach all pertinent documents that are available)

REPORTS: Detailed Referral Letter, Operative Report, Pathology Reports, Blood Work
IMAGING: CT Scan, PET Scan, Chest X-Ray, Ultra sound, Bone Scan, Mammogram, MRI, Other

Are any results still pending? ☐ Yes ☐ No If **yes**, please provide any additional information/details on specific results pending:

NPR Office Use Only: Physician: _____ Appointment Date: _____ Time:_____
Clinic appointment notification sent to: ☐ Referring Physician ☐ Patient ☐ Other (specify):_____

Cancer Centre of Southeastern Ontario
A Cancer Care Ontario Partner
Kingston Health Sciences Centre
QHC Quinte Healthcare

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Referrals are booked to the first available oncology appointment (usually within 2 weeks). **THE REFERRING PHYSICIAN MUST CALL TO SPEAK WITH THE ONCOLOGIST FOR EMERGENT CASES WHERE THE PATIENT NEEDS TO BE SEEN WITHIN 24 HOURS.**

To complete the referral process please include:

- Completed referral form
- All diagnostic tests in relation to workup of patient's diagnosis
- Pathology reports
- Recent imaging
- Bloodwork
- Lab reports that are relevant to cancer diagnosis
- Operative (OR) reports
- Prior pathology (if any malignant diagnosis)
- Clinic notes
- Referral letter indicating current symptoms, the history of the present illness, past medical history and current list of medications

Referral will be faxed back to referring Health Care Provider if referral is incomplete.

Abbreviation	Definition
DOB	Date of birth
OHIP	Ontario Health Insurance Plan
Ext.	Extension
CNS	Central nervous system
GI	Gastrointestinal
GU	Genitourinary
CT	Computed tomography
MRI	Magnetic resonance imaging
PCS	QuadraMed Patient Care System