



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 <input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> 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): _____



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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 |