

NOTE: Incomplete and / or unsigned requisitions will be returned

PLEASE PRINT CLEARLY OR AFFIX LABEL WITH COMPLETE INFORMATION

MARKHAM STOUFFVILLE HOSPITAL CORPORATION

MARKHAM ONCOLOGY REFERRAL

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Please Fax To: 905-472-7046

Telephone: 905-472-7373 ext. 6659

| | |
|-----------------------------|---------------------------|
| Hospital MRN #: | _____ |
| Patient Name: | _____ |
| Date of Birth: | _____ Sex: F M |
| Health Card # | _____ Version Code: _____ |
| Address: | _____ Postal Code: _____ |
| Telephone # (Best Daytime): | _____ |
| Alternate #: | _____ |

Emergent (less than 24 hours).
Must speak directly to the on-call oncologist - Page the oncologist through locating

Urgent (less than 7 days). Explanation: _____

Routine (less than 14 days)

| | | |
|---------------------------------------|--|-----------|
| Referral Date (mm/dd/yy) | Referring MD | Billing # |
| Telephone | Fax | Address |
| Spoken Language if other than English | Contact Information for Translator if Required (Name & Number) Please bring a translator to the appointment if required. | |

Diagnosis: _____

Patient aware of diagnosis: Yes No

Reason for Referral: New Diagnosis Recurrent/Progression 2nd Opinion

Details: _____

Recent Imaging Relevant to Diagnosis: If Pending, note date and location of test booked

| | |
|--|---|
| <input type="checkbox"/> CT | <input type="checkbox"/> MRI |
| <input type="checkbox"/> Mammogram _____ | <input type="checkbox"/> Ultrasound _____ |
| <input type="checkbox"/> Bone Scan _____ | <input type="checkbox"/> X-ray _____ |
| <input type="checkbox"/> FDG-PET _____ | <input type="checkbox"/> Echo _____ |
| <input type="checkbox"/> Skeletal Survey (myeloma) _____ | <input type="checkbox"/> _____ |

Please include available reports and ensure patient brings images on CD

Please include the following:

| | |
|--|--|
| Brief History: <input type="checkbox"/> Included <input type="checkbox"/> Pending | Most recent consult note: <input type="checkbox"/> Included <input type="checkbox"/> Pending |
| Recent Pathology: <input type="checkbox"/> Included <input type="checkbox"/> Pending | Previous Pathology: <input type="checkbox"/> Included <input type="checkbox"/> Pending |
| Medication List: <input type="checkbox"/> Included <input type="checkbox"/> Pending | Recent Lab Reports: <input type="checkbox"/> Included <input type="checkbox"/> Pending |
| Operative Report: <input type="checkbox"/> Included <input type="checkbox"/> Pending | _____: <input type="checkbox"/> Included <input type="checkbox"/> Pending |

***** All external information MUST be faxed with this referral for appointment to be made *****

For office use only

| | | |
|---|-------------|------------------|
| Fax Complete: <input type="checkbox"/> Yes <input type="checkbox"/> No | Date: _____ | Appt Time: _____ |
|---|-------------|------------------|