

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

Dr. Henry Solow MD, FRCPC
Dr. Leena Hajra MSc, MD, FRCPC
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Dr. Vikaash Kumar, MD, MSc, FRCPC

Please Fax To: 905-472-0529

Telephone: 905-472-7072

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: _____
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