NOTE: Incomplete and / or unsigned requistions 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
Dr. Mateya Trinkaus, MD, FRCPC
Dr. Vikaash Kumar, MD, MSc, FRCPC

Please Fax To: 905-472-7046
Telephone: 905-472-7373 ext. 6659

Hospital MRN #: _____

Patient Name: _____
Last First

Date of Birth: _____ Sex: F M
Day Month Year

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

☐ CT		☐ MRI	
☐ Mammogram		☐ Ultrasound	
☐ Bone Scan		☐ X-ray	
☐ FDG-PET		☐ Echo	
☐ Skeletal Survey (myeloma)		☐ _____	

Please include available reports and ensure patient brings images on CD

Please include the following:

Brief History:	☐ Included ☐ Pending	Most recent consult note:	☐ Included ☐ Pending
Recent Pathology:	☐ Included ☐ Pending	Previous Pathology:	☐ Included ☐ Pending
Medication List:	☐ Included ☐ Pending	Recent Lab Reports:	☐ Included ☐ Pending
Operative Report:	☐ Included ☐ Pending	_____:	☐ Included ☐ Pending

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

For office use only

Fax Complete: ☐ Yes ☐ No Date: _____ Appt Time: _____