Mackenzie Health

Mackenzie Richmond Hill Hospital
10 Trench Street, Richmond Hill ON L4C 4Z3
905-883-1212

Cortellucci Vaughan Hospital
3200 Major Mackenzie Drive West, Vaughan ON L6A 4Z3
905-417-2000

Oncology External Referral Form

Patient Label Here

Mackenzie Richmond Hill Hospital
10 Trench Street, Richmond Hill, ON L4C 4Z3

FAX TO: 905-883-2156

Patient Information:

Last Name:	First Name:	Date of Birth: (dd/mm/yyyy)	Gender:
Street Address:			
City:	Province:	Postal Code:	
Health Card #:	Version Code:	Interpreter required? ☐ No ☐ Yes please specify language	
Phone (Home):	Phone (Cell):	Phone (Work):	
Alternative Contact Person:	Relationship:	Phone:	
Emergency Contact:	Relationship:	Phone:	
Family Doctor:	Phone:	Fax:	
Referral Date: (dd/mm/yyyy)	Please indicate the service requested: ☐ Medical Oncology ☐ Malignant Hematology		

Diagnosis / Reason for Referral:

☐ New Diagnosis ☐ Recurrent / Progressive ☐ Other:

Patient aware of diagnosis: ☐ Yes ☐ Pending (Please notify patient of diagnosis for an optimized Oncology consultation)

Urgency to Assessment:
☐ Routine (less than 14 days)
☐ Urgent (less than 7 days). Explanation:
☐ Emergent (less than 24 hours). Page the appropriate on call oncologist.

Please include the following, if available:

☐ Most recent Consult note	☐ Included	☐ Pending
☐ Medication List	☐ Included	☐ Pending
☐ Recent Lab Reports	☐ Included	☐ Pending
☐ Tumor Markers	☐ Included	☐ Pending
☐ Operative Report	☐ Included	☐ Pending
☐ Pathology Report	☐ Included	☐ Pending
☐ Other relevant consults	☐ Included	☐ Pending

Recent Imaging Relevant to Diagnosis:

☐ X-ray	☐ Included	☐ Pending
☐ Ultrasound	☐ Included	☐ Pending
☐ Mammogram	☐ Included	☐ Pending
☐ CT	☐ Included	☐ Pending
☐ Bone Scan	☐ Included	☐ Pending
☐ MRI	☐ Included	☐ Pending
☐ Other _____		

Please include as much information as possible and FAX COPIES OF ALL CONSULTATIONS / CLINICAL NOTES & REPORTS to 905-883-2156. Lack of information MAY DELAY appointment scheduling.

FOR QUERIES, PLEASE CALL 905-883-1212 Ext. 2153

Referring Physician Name: *(print first, last)*	Billing #:
Signature:	Date Sent: *(dd/mm/yyyy)*
Phone Number: ( )	Fax Number: ( )