Interlake-Eastern
Regional Health Authority

ADDRESSOGRAPH / DYMO LABEL

Cancer Navigation Services Referral Form

Fax to: 1-204-785-9242

Toll Free Telephone: 1-855-557-2273

Date of Referral: DD – MMM - YYYY ____________ Family Physician: ____________
Referral Source Name: ____________ Telephone: ____________
Telephone: ____________
Patient Aware of Referral? ☐ Yes ☐ No

Patient Information

Surname: ____________ Address: ____________
Given Name: ____________ City / Town: ____________
DOB: DD – MMM – YYYY Sex: M ☐ F ☐ Postal Code: ____________
PHIN: ____________ Home Phone: ____________
MHSC: ____________ Cell Phone: ____________
CR #: ____________ Work Phone: ____________
Call Contact First As Patient: ☐ Is hearing impaired ☐ Has Dementia ☐ Other:
Next of Kin / Contact Name: ____________ Relationship: ____________
Home Phone: ____________ Cell Phone: ____________

Patient Location
- ☐ Home
- ☐ Hospital Specify: ____________
- ☐ PCH Specify: ____________

Language Spoken / Understood:
- ☐ English
- ☐ French
- ☐ Other: ____________
- ☐ Interpreter Required

Reason for Referral (check all that apply):
- ☐ Suspicion
- ☐ Recurrence
- ☐ Practical resources
- ☐ New Diagnosis
- ☐ Non-Curative Disease
- ☐ Education and Information
- ☐ Psychosocial Counselling
- ☐ Bereavement
- ☐ Anxiety / Depression
- ☐ Other: ____________

Suspected / Confirmed Diagnosis: ____________

Is the patient aware of diagnosis / suspicion? ☐ Yes ☐ No

Indicate tests that have been done / ordered / pending? Include dates and copy of available results.
If results pending, indicate site of test
- ☐ CT Date: ____________
- ☐ X-Ray Date: ____________
- ☐ Other: ____________
- ☐ MRI Date: ____________
- ☐ U/S Date: ____________
- ☐ Tumor Markers Date: ____________
- ☐ Bone Scan Date: ____________
- ☐ MUGA Date: ____________
- ☐ Blood work Date: ____________
- ☐ Pathology / Cytology: ____________

Has Oncology referral been faxed to CCMB Central Referral Office? ☐ Yes ☐ No
Have other referrals been sent? ☐ Yes ☐ No
If yes, to whom:
Additional Comments:

* Please attach progress note or any other relevant information

---For Office Use Only---
Referral Received: DD – MMM – YYYY ____________ Navigator Assigned To: ____________