CancerCare Manitoba
ActionCancerManitoba

INFORMATION REQUIRED BY CCMB REFERRAL CENTRE—
OVARY OR PELVIC MASS NYD (GYNECOLOGIC ONCOLOGY DSG):

Key:

shaded text – denotes **required** information

***** (asterisk) – denotes optional information
Please send results/reports if done.

1. GENERAL INFORMATION

- Demographic information (New Patient Referral Form)
- Letter of referral
- History and physical
- Co-existing medical conditions
- Allergies
- Previous malignancy information (diagnosis and previous treatment)

2. PATHOLOGY REPORTS

Attach copy of ORIGINAL REPORT(S):

- Oophorectomy / hysterectomy pathology and cytology (3 pelvic washings) *

3. OPERATIVE REPORTS

- Reports from oophorectomy / hysterectomy *

4. IMAGING REPORTS / STAGING INVESTIGATIONS

- Chest x-ray PA and lateral views *
- Abdominal and pelvic ultrasound or CT abdomen and pelvis *

5. BLOODWORK

- CBC *
- Biochemistry including electrolytes, BUN, creatinine, LFT's *
- CA 125 *

6. OTHER INFORMATION

- EKG *

***Please Note**: If referring physician has ordered tests, but they are not yet done, please provide dates (if available) and location where test is being done.*

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INSTRUCTIONS FOR PREPARING & SUBMITTING–
CancerCare Manitoba's *New Patient Referral Form*

*You can fill in the CCMB **New Patient Referral Form** (next page of this pdf file) using an Adobe Acrobat application (e.g. Reader, Pro) on your computer. If you are using Adobe Reader5.0 or higher to perform this task, please note that **Adobe has disabled the "save form" feature.** Therefore, after you fill in the form, be sure to print a copy(ies) before closing the window to avoid losing your data. Alternatively, you may print a blank form and fill it in by hand.*

As you do so, please follow these instructions:

1. Attach the "required referral information" specific to the DSG (or area of specialization) that is detailed in the preceding page(s) of this download package.

2. If the referring physician has ordered investigations that have not yet been completed or results are pending, please provide dates and location in the space provided on the referral form. For those referring offices that submit referral information from an electronic chart source, we request that the referral information be sent as separate documents, each labeled with the patient's name and health number. (i.e. x-ray report on one page, CBC on a separate page, operative report on another page, CT scan on its own page, etc.).

3. Have the Referring Physician **SIGN THE FORM**.

4. Please send above information together with the CCMB referral form by **FAX** to (204) 786–0621.

5. If the referring physician has or will be referring the patient to a community medical oncologist, please indicate this on the referral letter.

6. Please note if any investigations indicated were not completed or if the results are still pending. Lack of pertinent information **MAY DELAY** the scheduling of the patient's appointment. Additional investigations may be organized prior to the patient's first appointment.

7. If the referral is **emergent** (i.e.: your patient needs to be seen within 24 to 48 hours for immediate treatment with chemotherapy, radiation therapy or surgery for a life-threatening oncological emergency), please phone the Medical or Radiation Oncologist or surgical service on-call through paging at Health Sciences Centre: (204) 787-2071 or at St. Boniface General Hospital: (204) 237-2053.

8. For **hematologic emergencies** please page the on-call hematologist at the above phone numbers.

9. **Is the patient aware of the diagnosis?** All patients should be made aware of their diagnosis by the Referring Physician prior to being referred to CancerCare Manitoba. CancerCare Manitoba staff will be contacting new patients by telephone to provide further information about their first appointment. If the patient is not aware of their diagnosis and referral to CancerCare Manitoba, they may experience undue stress and anxiety.

If you have a referral-related inquiry, please call (204) 787–2176.

CancerCare Manitoba
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Manitoba's Centre for Cancer Control & Blood Disorders

Referral by Fax: 786 - 0621
Phone Inquiry: 787 - 2176

NEW PATIENT REFERRAL FORM

OPTIONS FOR ENTERING DATA ON THIS FORM:
1. In Adobe Acrobat: Position your cursor in the first field below. Type the last name. Advance to the next field using the tab key. Tab & enter data to the bottom of the page. PLEASE NOTE that because Adobe has disabled the "save form" feature in Acrobat Reader 5.0 and later, you MAY NOT BE ABLE to save a copy of your form to your computer. Therefore to avoid data loss, print a copy(ies) of the form BEFORE YOU CLOSE THIS WINDOW.
2. By hand: Print off the form now and fill the information in by hand or typewriter. Include with your referral submission to CancerCare Manitoba.

* The Referring Physician MUST sign this form.
** This note disappears when the form is printed.

Patient Information (please print)

Surname: | Given Name: | Initial:

Maiden and Previous Name (s): | Date of Birth: ____/____/____ (day / month / year) | Sex: M ☐ F ☐

Address: | City: | Province: | Postal Code:

Phone: Home: ( ) | Work: ( )

Patient location: Home ☐ Hospital ☐ Specify unit:_____ Unit phone #: _____

Manitoba Health # : | PHIN# :

Does the patient have any special needs?
Wheelchair: ☐ Portable oxygen: ☐
Stretcher: ☐ Other:_____

Does the patient speak English? Yes ☐ No ☐
If no, what language:_____
Need for a translator? Yes ☐ No ☐

Referral Information: to be completed and signed by the referring Physician

Diagnosis:
Confirmed ☐ Presumptive ☐

Is the patient aware of diagnosis?
Yes ☐
No ☐ If no, please explain:_____

Reason for Consultation:
Newly Diagnosed ☐ 2nd Opinion ☐
Recurrent / Progressive Disease ☐

Comments:

Surgeon's Name (if different from referring physician):

Family Physician (if different from referring physician):

Referring Physician's Name:

Tel: ( )
Fax: ( )

Today's Date: dd / mm / yyyy (day / month / year)

Signature of referring physician: **(Required)**

Required Information:	Sent with Referral	If result pending state date and place done:
1) Letter (with History & physical; co-existing conditions; allergies; previous malignancy)		
2) Pathology		
3) Operative reports		
4) Imaging		
5) Blood work		
6) Other		

Patients will be notified of receipt of referral.
Please complete & fax this form together with required information.
Lack of pertinent information MAY DELAY scheduling of patient's appointment.