NORTHERN HEALTH REGION

ADDRESSOGRAPH / DYMO LABEL

Cancer Navigation Services Referral Form

Fax to: 1-204-677-5387

Toll Free Telephone: 1-855-740-9322

Date of Referral: DD – MMM - YYYY

Family Physician:

Referral Source Name:

Telephone:

Telephone:

Patient Aware of Referral? ☐ Yes ☐ No

Patient Information

Surname:

Given Name:

DOB: DD – MMM – YYYY Sex: M ☐ F ☐

PHIN:

MHSC:

CR #:

Address:

City / Town:

Postal Code:

Home Phone:

Cell Phone:

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:

Revision Date: May 25, 2015