Southern Health Santé Sud

ADDRESSOGRAPH / DYMO LABEL

Cancer Navigation Services Referral Form Fax to: 1-204-331-8899

Toll Free Telephone: 1-855-623-1533

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

Family Physician:
Telephone:

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:
Home Phone:

Relationship:
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: June 23, 2016