

Patient Referral Form

Referral Centre	Contact Numbers
☐ Allan Blair Cancer	Fax: 306-766-2939
Centre (ABCC)	Phone: 306-766-2213
☐ Saskatoon Cancer	Fax: 306-655-6610
Centre (SCC)	Phone: 306-655-2662

NOTE:

- 1. Please <u>print</u> and reply to all questions. The cancer center will notify your patient of the date and time of their appointment.
- 2. To expedite the new patient appointment there is a list of required tests to be competed (or ordered and in process) based on disease site (see page 2). Fax (see number above) this completed form with required attached documents to respective referral centre.
- **3.** For emergency/urgent referrals, please phone the appropriate referral centre (ABCC or SCC number above). Also page the on call oncologist/hematologist as appropriate.

Patients Name: _					Sex: □ l	Male	☐ Female
Ī	First	Last		Initial			
Mailing Address:				City	r:		
Province:	Postal Co	de:	Phone: _		Cell:		
Date of Birth:	Date/Month/Yea	ar Pe	ersonal Healt	h Number: _			
Next of Kin/Conta	act:				Phone:		
Family Physician	:				Phone:		
Cancer Diagnosi	s:						
Patient is aware	of: □ Diagnosis ar	nd □ Referral	(Please do n	ot send refe	rral until both are	compl	ete)
Reason for Con	sultation: □ New	ly Diagnosed	d □ Rec	urrent/Progre	essive Disease		2nd Opinion
Has this patient h	nad definitive surge	ry: □ Yes □	No, but req	uires consult	with an oncologis	st befo	re surgery
Patients Location	n: □ Hospital □	l Ward	☐ Home	☐ Other:			
Does the patient	require an interpre	ter? □ Yes, fo	or what langu	age:			□ No
Does the patient	have any special n	eeds?					
☐ Wheelchair	☐ Stretcher	□ Portab	ole Oxygen	☐ Other: _			
Does the patient patients?	have an infectious	disease for w	hich precauti	ons need to	be taken to proted	ct staff	and other
□ No □ Yes, ha	is:						
Comments if any	r:						
Signature of Re	ferring Physician:						
Name of Referri	ng Physician:						
Date:	Phor :h/Year	ne:		Fax:			