Erie St. Clair
Regional Cancer Program
Ontario Health (Cancer Care Ontario)

INDIGENOUS PATIENT REFERRAL FORM

All information MUST be complete for the referral to be processed.
Incomplete or unsigned referrals will be returned for completion.

PATIENT INFORMATION (Please Print)

Surname

Given Name(s)

Date of Birth
_____ / _____ / _____
dd *mm* *yy*

Gender
□ Male □ Female

OHIP # (Include Version Code)

Address

City/Province

Postal Code

Patient's Contact Information

Home _____
Work _____
Cell _____

Contact Person
Name _____
Relationship _____
Home _____
Work _____ **Cell** _____

CLINICAL INFORMATION

Other support agencies: _____

_____

Location: _____

_____

Family Doctor: _____

Telephone: _____

Date of Interaction: _____

Method of Interaction: _____

Patient Informed of reason for Referral?

□ Yes □ No

Date patient was informed:

_____

*Note: Patient **must** be informed of referral reason*

Reason for Referral

□ Support Program
□ Educational Program
□ Diversional Program
□ Volunteer Services
□ Complementary Services

WINDSOR REGIONAL HOSPITAL – CANCER PROGRAM USAGE ONLY

Next of Kin
Name _____ **Relationship** _____
Address _____ **Postal Code** _____
Telephone (H) _____ **(W)** _____ **(C)** _____

Family/Significant Others

Name	Relationship	Phone Number

Fax completed forms to (519)255-8670
ATTENTION: LOUISE CERVINI, INDIGENOUS NAVIGATOR