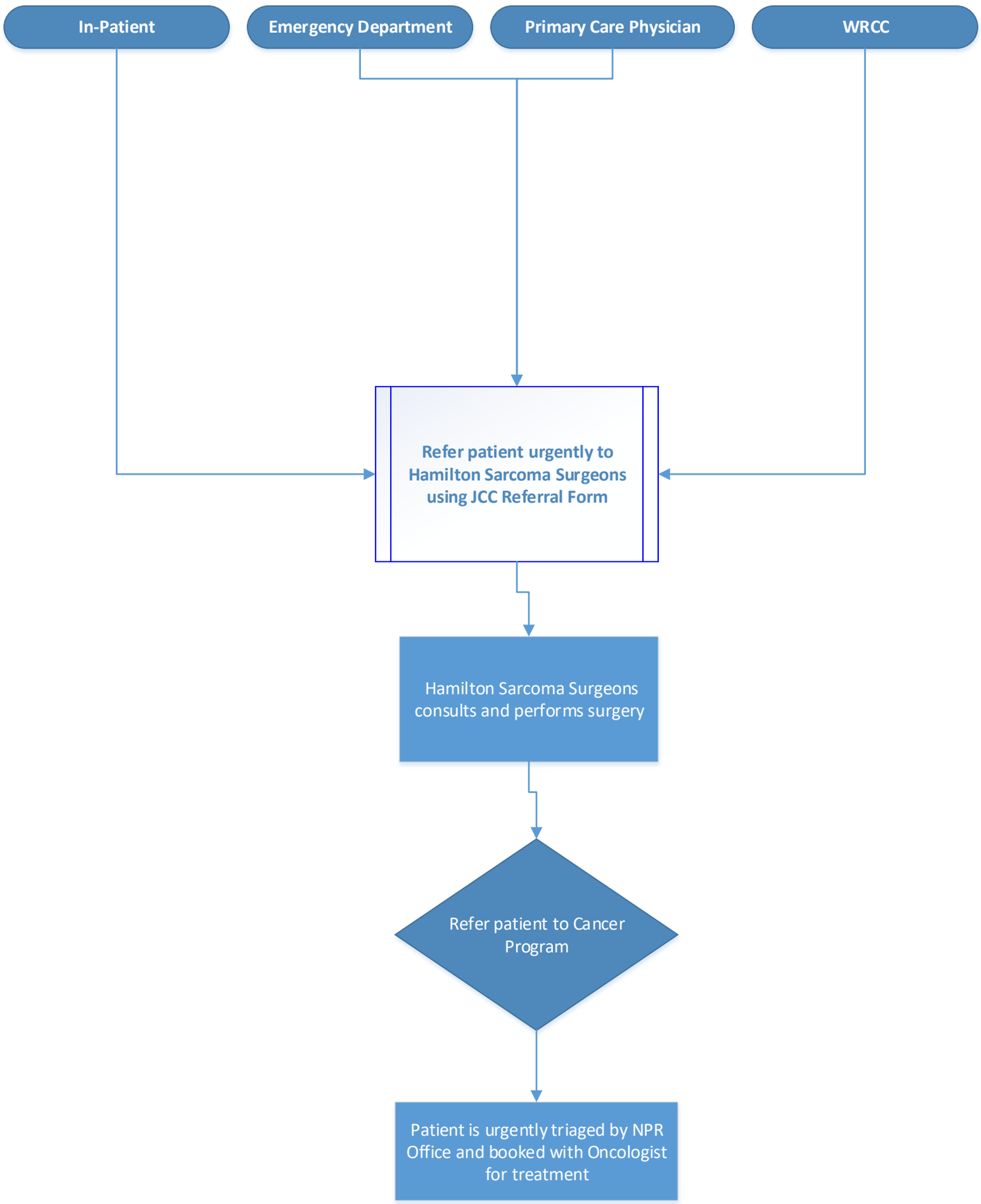
Body Sarcoma Pathway – Suspected Soft Tissue Sarcoma Involving Body



Juravinski Cancer Centre
HAMILTON HEALTH SCIENCES

PATIENT REFERRAL FORM

Outpatient Oncology New Patient Referral
Juravinski Cancer Centre
699 Concession Street, Hamilton, ON, L8V 5C2
Please **COMPLETE ALL INFORMATION** and **FAX TO 905-575-6316 WITH ALL RELATED REPORTS**. Please note that a lack of information **MAY DELAY** appointment scheduling.

Please Print

PATIENT INFORMATION

Patient's Name:	M ☐ F ☐	Date of Birth (dd/mm/yy):
Health Card Number:	Version Code:	Language (if English not spoken):
Address:		
City:	Province:	Postal Code:
Phone (primary):	Phone (secondary):	

Patient Location: ☐ Home ☐ Hospital _____
Hospital/Inpatient Unit/Unit Extension

Alternate Contact:	Relationship:	Phone:
Referring Physician:	Fax:	Phone:
Family Physician:	Fax:	Phone:

NOTE: This patient remains under the care of the referring physician until seen by an Oncologist at JCC

CLINICAL INFORMATION

Diagnosis:

Patient Informed of Diagnosis ☐ YES ☐ NO
☐ Emergency/Urgent

ARO Status
MRSA ☐ Pos ☐ Neg
VRE ☐ Pos ☐ Neg
Other: _____

Requested Service(s):
☐ Medical Oncology
☐ Radiation Oncology
☐ Surgical Oncology
☐ Palliative Care

Primary Site:
☐ Breast ☐ Gyne ☐ Melanoma ☐ Haematology
☐ CNS ☐ Head & Neck ☐ Skin (Non-Melanoma) ☐ Other (specify): _____
☐ G.I. ☐ Lung ☐ Supportive Care
☐ G.U. ☐ Lymphoma ☐ Genetics

Reason for Consultation:
☐ New Diagnosis ☐ Recurrent/Progressive Disease ☐ 2nd Opinion ☐ Telemedicine Request
Other:
Comments:

Previous Cancer Treatment:
☐ YES ☐ NO Facility: _____
☐ Chemotherapy ☐ Radiation
Other:

Investigations Scheduled (including Date & Testing facility):

Investigations Completed and Faxed:

Reports:	Faxed	Radiology:	Faxed
Referral Letter/H&P	☐	X-Ray	☐
Operative/Scopes	☐	Ultrasound	☐
Pathology Reports	☐	Bone Scan	☐
Blood Work	☐	CAT Scan	☐
Pulmonary Functions	☐	Mammogram	☐
		Receptors	☐
		MRI	☐

NOTE: ANY missing information MAY DELAY the processing of this referral

_____ _____
Signature of referring physician (mandatory) **Date (dd/mm/yy)**

We will contact the referring doctor with an appointment