CAMBRIDGE MEMORIAL HOSPITAL
700 Coronation Blvd.,
Cambridge, ON N1R 3G2
519-621-2330

Oncology/Palliative Care

Patient Referral Form

FAX: 519-740-7722

PATIENT INFORMATION (Complete form required. Incomplete forms WILL be returned)

Patient Name:		Date of Referral:
Address:		CMH Unit #: _____ Health Insurance #:
Date Of Birth:	Home Telephone #:	Business/Other Telephone #:
Next of Kin:		Telephone Number #:
Patient Currently:	Home: ❑ Hospital: ❑	Other:
Referring Physician:	Telephone #:	Fax #:
Billing #:		
Family Physician:	Telephone #:	Fax #:

Referral Disease Site:

❑ Breast ❑ Gastrointestinal ❑ Lung ❑ Genitourinary ❑ Melanoma

❑ Hepatobiliary/pancreatic ❑ Other:_____

Service Requested: ❑ Medical Oncologist ❑ Radiation Oncologist Is patient aware of their diagnosis ❑ Yes ❑ No

Newly Diagnosed: Recurrent/Progressive Disease:

Procedures Relative To Condition

Operations/Procedures	Hospital	Date	Tissue #

Diagnostic Imaging

	Done		Location Completed	
	Yes	No		Date
Mammogram	❑	❑		
X-ray	❑	❑		
CT	❑	❑		
Ultrasound	❑	❑		
MRI	❑	❑		
Nuclear Medicine	❑	❑		
Laboratory Tests	❑	❑		

Signature of Referring Physician:_____ _____
(Physician) (Date)

TO BE COMPLETED BY CMH ONCOLOGY STAFF

Clinic Appointment Date:_____ Booked to:_____

Given to: Referring Physician ❑ Patient ❑ Hospital Staff ❑

Date:_____ Intake/Triage/Clerical Associate:_____