BLUEWATER HEALTH

Place Patient Label Here

# Oncology New Patient Referral Form

**Referral accepted through OCEAN eReferral Network or FAX**
**Please fax form to 519-383-8532**
**Bluewater Health Oncology 519.464.4400 Ext 5517**
**Patients will remain under the care of the referring healthcare provider until seen by the oncologist.**

| | | |
|---|---|---|
| Name: | Female Male | Referral Date (YYYYMM/DD) |
| Address: | | OHIP Number and version code |
| Phone Number | | Date of Birth (YYYY/MM/DD) |
| Patient Currently: Home Hospital (Name) | Call appointment to: Patient Physician Hospital | |

## REFERRAL INFORMATION ( To be completed by referring Healthcare Provider)

| | | |
|---|---|---|
| Referring Providers Name: | Billing Number | Phone ( )<br>FAX ( ) |
| Family Provider's Name: | Address: | Phone ( ) |
| Working Diagnosis:<br><br>Patient Informed of Diagnosis: Yes No | | |
| Previous Cancer Treatment:<br>Yes No | Chemotherapy:<br>Radiation Therapy: | Other: |
| Surgery ( Procedure, Date, Hospital)<br><br>Pathology:<br><br>Diagnostic Tests<br>(Blood work/ Imaging- include Procedure, Date, Location) | History<br><br>Signature of Referring Provider **(Mandatory)** _____ | |

**Service Requested:** Medical Oncologist

**BWH Follow Up ( BWH office use only)**

**Clinic Appointment Date:**

**Referred To :**

Dr. Yoshida Dr Lebert : Reviewed By: _____ _____ _____ _____
Physician Date Time

Appointment Date: _____