BLUEWATER HEALTH

Bluewater Health
Oncology New Patient Referral Form

Place Patient Label Here

Referral accepted by 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 ( ) FAX ( )
Family Provider's Name:	Address:	Phone ( )
Working Diagnosis: Patient Informed of Diagnosis: ☐ Yes ☐ No		
Previous Cancer Treatment: ☐ Yes ☐ No	Chemotherapy: Radiation Therapy:	Other:
Surgery (Procedure, Date, Hospital) Pathology: Diagnostic Tests (Blood work/ Imaging- include Procedure, Date, Location)	History 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: _____