BLUEWATER HEALTH

Bluewater Health
Oncology New Patient Referral Form

Place Patient Label Here

NEW PATIENT REFERRAL FORM

Please fax completed form to 519-383-8532
All below information is Mandatory. Incomplete or unsigned referrals will be returned.

Referral information:

○ Patient has been informed of diagnosis **(we don't contact patients with appointments unless they have been informed)**			
Referral Type: ○ Standard (2 weeks) ○ Urgent (72 hours) ○ Emergency (24 hours) *If your referral is either an urgent or emergency referral, please call the oncology clinic to speak directly to one of the oncologist at 519-464-4500 Ext 7085*	Requested Service: Med Oncology Palliative Care Requested Physician and Primary Site		
	Dr Yoshida, Medical Oncologist: ○ Breast ○ G.I. ○ G.U ○ Gyne ○ Hematology ○ Neuroendocrine ○ Thoracic ○ Unknown Primary	Dr Lebert, Medical Oncologist: ○ Breast ○ G.I. ○ G.U ○ Thoracic ○ Unknown ○ Primary	Dr Lilly, GP Oncologist: ○ Palliative Care

Note: This patient remains under the care of the referring physician until seen by an oncologist

Patient information:

Surname:	Given Name(s):
Date of Birth: _____ /_____ / _____ DD MM YYYY	Gender: Male Female
OHIP # (including version code:	Preferred Language:
Address:	Home: _____ Cell: _____ Work: _____
Additional patient information:	

Investigations completed:

Test	Anatomical location	Date	
Biopsy			Please attached copy to referral
CT			Please attached copy to referral
MRI			Please attached copy to referral
Bone scan			Please attached copy to referral

Referring Primary Care Practitioner:

Name:	Signature:
Date: MM/DD/YYYY	Phone:
Fax:	OHIP Billing: