

**Oncology Patient Navigation Program (OPNP) Referral Form**

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| **TEL: (519) 685-8500 ext: 53232 FAX: (519) 432-1805** | | | | | |
| **PATIENT INFORMATION** | | | | Date of Referral: | |
| **First Name:** | **Last Name:** | | | | Date of Birth: |
| Address: | | Apt. #: | | | City, Town, Village: |
| Postal Code: | Phone Number: | | | | OHIP: |
| Translator Required:  **Yes  No**  SpecifyLanguage**:** | | | **Is patient aware of referral?  Yes  No**  **Is the patient aware of potential cancer diagnosis?  Yes  No** | | |
| **Please select area of concern:**  **Anal**  **Lung**  **Rectal** | | | | | |
| **For lung referrals please provide most recent CT thorax report.** | | | | | |
| Reason for referral/pertinent presenting symptoms: | | | | | |
| Significant past medical history: *(Can attach Cumulative Patient Profile)* | | | | | |
| Recent related diagnostic tests: | | | | | |
| **FAX WITH REFERRAL FORM**  Pertinent imaging reports  Blood work results within last 3 months  ***(including. chest x-ray, CT chest scan) (including CBC, INR/PTT, Urea, Creatinine, Electrolytes)***  Current list of medication  Pathology /cytology results (if available) | | | | | |
| **REFERRING PHYSICIAN**  Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Physician Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | **FAMILY PHYSICIAN *(if not referring physician)***  Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| **PLEASE INFORM ALL PATIENTS OF REFERRAL. OPNP WILL CONTACT PATIENT DIRECTLY WITH APPOINTMENT.**  **NOTE: An incomplete referral form may lead to delays in appointment booking.** | | | | | |