JOSEPH BRANT HOSPITAL

New Patient Referral Form

Please complete all information and include all related reports with this request and fax to 905 681-4955.

Lack of information may delay your patient from being seen in a timely manner.

If this referral is **EMERGENT**, please phone the clinic office directly at **905 336 4103**

Patient Information

Patient Name: _____

Address: _____

_____

Date of Birth: _____

Phone: (____) _____

Alternate contact: (____) _____

Ontario Health Card Number: _____

☐ Out-of-Province ☐ Out-of-Country

Referring Physician Information

Referring Physician: _____

Address: _____

_____

Phone: (____) _____

Fax: (____) _____

Billing #: _____

(may use this space for stamp/label if applicable)

Consultation Requested:

☐ Medical Oncology

☐ Haematology

☐ Radiation Oncology

Reason for Referral (diagnosis): _____

Previous Cancer Treatment: ☐ No, never ☐ Yes, Chemotherapy ☐ Yes, Radiation

If yes, previous treatment facility: _____

Is patient aware of diagnosis for which this referral is being sent? ◯ Yes ◯ No

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Clinical documentation/enclosed reports to date	faxed	Meditech/Clinical Connect
☐ Referral Letter	☐	☐
☐ Patient History & Consult notes	☐	☐
☐ Lab – If labs are pending please indicate the lab: _____	☐	☐
☐ Imaging – If images are pending please indicate the location: _____	☐	☐
☐ Pathology & Cytology	☐	☐
☐ Operative Reports	☐	☐
☐ Other: _____		

Patient Location: ☐ Home ☐ Hospital ☐ Nursing Home ☐ Other: _____

Please Note:
Once this referral is processed, you will receive a New Patient Appointment Confirmation via fax and we will notify your patient directly of the appointment in a timely manner.