CANADIAN CANCER CARE
#110, 6925 GATEWAY BLVD NW
EDMONTON, AB, T6H 2J1
PHONE: 780-306-5656
FAX: 780-306-5757

FAX COMPLETED FORMS TO 780-306-5757. REFERRALS WILL NOT BE PROCESSED IF FORM IS INCOMPLETE

PATIENT INFO/LABEL	**Name:**		Gender: ☐ Male ☐ Female ☐ Other
	Address (including city & postal code):		
	Best Contact Phone number:		
	ULI/AHC #:	**D.O.B:**	
REFERRED BY (if different from Family Physician)	**Name:**	**PRAC-ID:**	Specialty:
	Address (including city & postal code):		
	Phone:	**Fax:**	Email:
FAMILY PHYSICIAN **☐ NO FAMILY PHYSICIAN**	**Name:**	PRAC-ID:	
	Address (including city & postal code):		
	Phone	**Fax:**	Email:

REFERRAL INFORMATION		
REASON FOR REFERRAL	☐ *Consultation & follow up/work up of abnormal findings* ☐ *Palliative care, symptom and/or pain management* ☐ *No family doctor & requiring follow-up of cancer care* ☐ *Procedure Request (e.g., endometrial biopsy, nasal endoscopy, lumps/bumps/skin lesion removal)* ☐ *Cancer screening inquiries* ☐ *Post-cancer treatment follow up inquiries*	Other:
TYPE OF REFERRAL	**☐ Consultation only** **☐ Consultation & short term follow up of specific inquiries (e.g., pain management, follow up of imaging/referral, work-up of abnormal findings, procedure request)** **☐ Consultation & request to take over care**	
PATIENT MEDICAL HISTORY *If known: past medical history, surgical history, medications, allergies, family history*		

Is there any imaging that is <u>not available</u> on Netcare for our review? ☐ Y ☐ N

Are there any <u>pending referrals</u> for our review? ☐ Y ☐ N **If yes, who/when:** _____

Is the patient aware of this referral? ☐ Y ☐ N **Is the Family Doctor aware of this referral?** ☐ Y ☐ N ☐ No Family Doctor

REFERRING MD SIGNATURE: _____

DATE OF REFERRAL: _____