

## INFORMATION REQUIRED BY CCMB REFERRAL CENTRE— OVARY OR PELVIC MASS NYD (GYNECOLOGIC ONCOLOGY DSG):

### 1. GENERAL INFORMATION

- Demographic information (New Patient Referral Form)
- Letter of referral
- History and physical
- Co-existing medical conditions
- Allergies
- Previous malignancy information (diagnosis and previous treatment)

#### Key:

**shaded text** – denotes **required** information

\* (asterisk) – denotes optional information  
*Please send results/reports if done.*

### 2. PATHOLOGY REPORTS

*Attach copy of ORIGINAL REPORT(S):*

- Oophorectomy / hysterectomy pathology and cytology (3 pelvic washings) \*

### 3. OPERATIVE REPORTS

- Reports from oophorectomy / hysterectomy \*

### 4. IMAGING REPORTS / STAGING INVESTIGATIONS

- Chest x-ray PA and lateral views \*
- Abdominal and pelvic ultrasound or CT abdomen and pelvis \*

### 5. BLOODWORK

- CBC \*
- Biochemistry including electrolytes, BUN, creatinine, LFT's \*
- CA 125 \*

### 6. OTHER INFORMATION

- EKG \*

*Please Note: If referring physician has ordered tests, but they are not yet done, please provide dates (if available) and location where test is being done.*

## INSTRUCTIONS FOR PREPARING & SUBMITTING— CancerCare Manitoba's *New Patient Referral Form*

*You can fill in the CCMB New Patient Referral Form (next page of this pdf file) using an Adobe Acrobat application (e.g. Reader, Pro) on your computer. If you are using Adobe Reader 5.0 or higher to perform this task, please note that Adobe has disabled the “save form” feature. Therefore, after you fill in the form, be sure to print a copy(ies) before closing the window to avoid losing your data. Alternatively, you may print a blank form and fill it in by hand.*

*As you do so, please follow these instructions:*

1. Attach the “required referral information” specific to the DSG (or area of specialization) that is detailed in the preceding page(s) of this download package.
2. If the referring physician has ordered investigations that have not yet been completed or results are pending, please provide dates and location in the space provided on the referral form. For those referring offices that submit referral information from an electronic chart source, we request that the referral information be sent as separate documents, each labeled with the patient’s name and health number. (i.e. x-ray report on one page, CBC on a separate page, operative report on another page, CT scan on its own page, etc.).
3. Have the Referring Physician **SIGN THE FORM**.
4. Please send above information together with the CCMB referral form by **FAX** to (204) 786-0621.
5. If the referring physician has or will be referring the patient to a community medical oncologist, please indicate this on the referral letter.
6. Please note if any investigations indicated were not completed or if the results are still pending. Lack of pertinent information **MAY DELAY** the scheduling of the patient’s appointment. Additional investigations may be organized prior to the patient’s first appointment.
7. If the referral is **emergent** (i.e.: your patient needs to be seen within 24 to 48 hours for immediate treatment with chemotherapy, radiation therapy or surgery for a life-threatening oncological emergency), please phone the Medical or Radiation Oncologist or surgical service on-call through paging at Health Sciences Centre: (204) 787-2071 or at St. Boniface General Hospital: (204) 237-2053.
8. For **hematologic emergencies** please page the on-call hematologist at the above phone numbers.
9. **Is the patient aware of the diagnosis?** All patients should be made aware of their diagnosis by the Referring Physician prior to being referred to CancerCare Manitoba. CancerCare Manitoba staff will be contacting new patients by telephone to provide further information about their first appointment. If the patient is not aware of their diagnosis and referral to CancerCare Manitoba, they may experience undue stress and anxiety.

*If you have a referral-related inquiry, please call (204) 787-2176.*



**Manitoba's Centre for  
Cancer Control & Blood Disorders**

**NEW PATIENT REFERRAL FORM**

**Referral by Fax: 786 - 0621**

**Phone Inquiry: 787 - 2176**

**Patient Information (please print)**

Surname: \_\_\_\_\_ Given Name: \_\_\_\_\_ Initial: \_\_\_\_\_

Maiden and Previous Name (s): \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex: M F  
\_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
 day month year

Address: \_\_\_\_\_ City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Phone: Home: ( ) Work: ( )

Patient location: Home  Hospital  Specify unit: \_\_\_\_\_ Unit phone #: \_\_\_\_\_

Manitoba Health # : \_\_\_\_\_ PHIN# : \_\_\_\_\_

Does the patient have any special needs?  
 Wheelchair:  Portable oxygen:   
 Stretcher:  Other: \_\_\_\_\_

Does the patient speak English? Yes  No   
 If no, what language: \_\_\_\_\_  
 Need for a translator? Yes  No

**Referral Information: to be completed and signed by the referring Physician**

Diagnosis: \_\_\_\_\_ Is the patient aware of diagnosis?  
 Confirmed  Presumptive  Yes   
 No  If no, please explain: \_\_\_\_\_

Reason for Consultation: \_\_\_\_\_ Comments: \_\_\_\_\_  
 Newly Diagnosed  2<sup>nd</sup> Opinion   
 Recurrent / Progressive Disease

Surgeon's Name (if different from referring physician): \_\_\_\_\_ Family Physician (if different from referring physician): \_\_\_\_\_

Referring Physician's Name: \_\_\_\_\_ Tel: ( )  
 Fax: ( ) Today's Date: \_\_\_\_\_ Signature of referring physician:  
\_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
 day / month / year  
**(Required)**

**Required Information: Sent with Referral If result pending state date and place done:**

1) Letter (with History & physical; co-existing conditions; allergies; previous malignancy)		
2) Pathology		
3) Operative reports		
4) Imaging		
5) Blood work		
6) Other		

**Patients will be notified of receipt of referral.  
 Please complete & fax this form together with required information.  
 Lack of pertinent information MAY DELAY scheduling of patient's appointment.**