

Central Referral Office

Referral by Fax: 204-786-0621

Inquiry: 204-787-2176

*For a complete Referral Package, please use the Referral Guide for the disease site involved.

Patient Identifiers required on each sheet submitted.

Referral Information Sheet

PATIENT INFORMATION LABEL / ADDRESSOGRAPH

Today's Date: _____

PATIENT INFORMATION

Required Information to accompany Referral Letter or Consult Request

Surname: _____	Address: _____
Given Name & Initial: _____	_____
Maiden or Previous Name(s): _____	City: _____
DOB: <u>DAY / MONTH / YEAR</u> Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Postal Code: _____
MB Health #: _____	Home Phone: _____
PHIN: _____	Work Phone: _____
Other: _____	Cell Phone: _____

Is English the patient's primary language? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, provide patient's primary language: _____ Need for interpreter? <input type="checkbox"/> Yes <input type="checkbox"/> No	Does the patient have any special needs? <input type="checkbox"/> Wheelchair <input type="checkbox"/> Stretcher <input type="checkbox"/> Portable Oxygen <input type="checkbox"/> Other: _____	Patient Location: <input type="checkbox"/> Home <input type="checkbox"/> Hospital-Specify Unit: _____ Unit Phone: _____
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REFERRAL INFORMATION

Diagnosis: _____ <input type="checkbox"/> Confirmed <input type="checkbox"/> Presumptive Reason for consultation: <input type="checkbox"/> Newly Diagnosed <input type="checkbox"/> Second Opinion <input type="checkbox"/> Recurrent/Progressive Disease Is patient aware of diagnosis? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, please explain: _____	Referring Physician's Name: _____ Phone: _____ Fax: _____ Surgeon (If not referrer): _____ Family Physician/Nurse Practitioner: _____ Comments:
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www.cancercare.mb.ca/referrals - Use the disease site specific Referral Guide for completeness, missing items may cause delay in triage process

REFERRAL PACKAGE CHECKLIST:	If result pending, state date and place done:
<input type="checkbox"/> Referral Letter (with history & physical, co-existing conditions, allergies, previous malignancy)	
<input type="checkbox"/> All Pathology & Operative Reports	
<input type="checkbox"/> All Diagnostic Imaging	
<input type="checkbox"/> All Blood Work	
<input type="checkbox"/> Other:	