

INFORMATION REQUIRED BY CCMB REFERRAL CENTRE— ENDOMETRIUM (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):

- Endometrial biopsy and/or D & C pathology*
- Hysterectomy pathology and cytology (3 pelvic washings) *

3. OPERATIVE REPORTS

- D & C*
- Hysterectomy *

4. IMAGING REPORTS / STAGING

- Chest x-ray PA and lateral views *

5. BLOODWORK

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

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*

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 2nd 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.**