

INFORMATION REQUIRED BY CCMB REFERRAL CENTRE— THYROID CANCER

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):

- ALL tissue biopsy report(s) (FNA, core biopsy, excisional biopsy)
- Pathology from definitive surgical procedure, if applicable *

3. OPERATIVE REPORTS

- Reports from any surgical biopsy procedure(s)
- Reports from definitive surgical procedure, if applicable *

4. IMAGING REPORTS / STAGING INVESTIGATIONS

- CXR *
- Thyroid ultrasound *
- CT scan neck and/or chest *
- MRI *
- Nuclear medicine procedures: thyroid scan *
Radioactive iodine *

5. BLOODWORK

- CBC *
- Biochemistry, including electrolytes, calcium, creatinine *
- TSH *
- Thyroglobulin *

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.

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:
	_____/_____/_____ day month year	M F

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: <input type="checkbox"/> Portable oxygen: <input type="checkbox"/> Stretcher: <input type="checkbox"/> Other: _____	Does the patient speak English? Yes <input type="checkbox"/> No <input type="checkbox"/> If no, what language: _____ Need for a translator? Yes <input type="checkbox"/> No <input type="checkbox"/>
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Referral Information: to be completed and signed by the referring Physician

Diagnosis: _____ Confirmed <input type="checkbox"/> Presumptive <input type="checkbox"/>	Is the patient aware of diagnosis? Yes <input type="checkbox"/> No <input type="checkbox"/> If no, please explain: _____
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Reason for Consultation: Newly Diagnosed <input type="checkbox"/> 2 nd Opinion <input type="checkbox"/> Recurrent / Progressive Disease <input type="checkbox"/>	Comments: _____
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Surgeon's Name (if different from referring physician): _____	Family Physician (if different from referring physician): _____
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Referring Physician's Name:	Tel: () Fax: ()	Today's Date: _____/_____/_____ day / month / year	Signature of referring physician: (Required)
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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.