



**NEW PATIENT REFERRAL**

**Please complete ALL information. Fax all related reports with this request (unless within Cerner)**

**PATIENT INFORMATION**

Name:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Referral (YYYY/MM/DD):
Address:		LRCP/LHSC Chart Number:
		Health Insurance Number:
Home/Cell Phone Number: ( ) ( )	Business Phone Number: ( ) ( )	Date of Birth (YYYY/MM/DD):
Patient Currently: <input type="checkbox"/> Home <input type="checkbox"/> Hospital Name of Hospital:		Call Appointment to: <input type="checkbox"/> Patient <input type="checkbox"/> Physician <input type="checkbox"/> Hospital

**REFERRAL INFORMATION (To be completed by Referring Physician)**

Referring Physician Name:	Billing Number:	Phone Number: ( ) ( ) Fax Number: ( ) ( )
Family Physician Name:	Address:	Phone Number: ( ) ( )
Working Diagnosis		
Patient Informed of Diagnosis: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Previous Cancer Treatment <input type="checkbox"/> Yes <input type="checkbox"/> No	Chemotherapy: Radiation Therapy:	Other:
Surgery (Procedure, Date, Hospital)  Pathology:  Diagnostic Tests (Blood Work/Imaging – Include Procedure, Date, Location)	History          <b>Referring Physician Signature</b>  _____ Date	

**LRCP FOLLOW-UP (For LRCP Office Use Only)**

Clinic Appointment	Doctor/Service Requested
Given to: <input type="checkbox"/> Patient <input type="checkbox"/> Physician <input type="checkbox"/> Hospital	<input type="checkbox"/> Secretary <input type="checkbox"/> Other (state)  Reviewed By: _____ Physician Date Time
Appointment Cancelled by:	Reason:
Rebooked Appointment:	
Information Taken By:	Booked: