



NEW PATIENT REFERRAL

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

PATIENT INFORMATION

Name:		Sex: ☐ Male ☐ 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: ☐ Home ☐ Hospital Name of Hospital:			Call Appointment to: ☐ Patient ☐ Physician ☐ 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: ☐ Yes ☐ No			
Previous Cancer Treatment ☐ Yes ☐ No	Chemotherapy: Radiation Therapy:		Other:
Surgery (Procedure, Date, Hospital) Pathology: Diagnostic Tests (Blood Work/Imaging – Include Procedure, Date, Location)		History Referring Physician Signature _____ Date	

LRCP FOLLOW-UP (For LRCP Office Use Only)

Clinic Appointment		Doctor/Service Requested	
Given to: ☐ Patient ☐ Physician ☐ Hospital		☐ Secretary ☐ Other (state) _____	
		Reviewed By: _____ Physician Date Time	
Appointment Cancelled by:		Reason:	
Rebooked Appointment:			
Information Taken By:		Booked:	