CancerCare Manitoba
ActionCancerManitoba

Central Referral Office
Send Referrals by Fax: 204-786-0621
For Inquiries Call: 1-844-320-4545

CancerCare Referral Form: CNS

Referral Date:

REFERRAL INSTRUCTION

- A complete referral **must include**:
  a. This referral form
  b. Referral letter including history of present illness, past medical history, and medication list
  c. Disease site-specific referral requirements on page 2 of this form
- Incomplete referrals will be returned
- Patient must be aware of referral to CancerCare Manitoba
- If the referral is emergent, please phone the "on call" medical or radiation oncologist, gynecologic oncologist, surgical service or hematologist through paging for Health Sciences Centre at 204-787-2071 or St. Boniface Hospital paging at 204-237-2053.

PATIENT INFORMATION

Surname: Given name & initial: Previous name(s): Preferred name (if different from given name): DOB: PHIN: Need for an interpreter? ☐ Yes ☐ No Specify language:	Address: City: Postal Code: Preferred Phone: Emergency contact/support person name: Relationship: Preferred phone:

REFERRAL INFORMATION

Diagnosis: ☐ Presumptive ☐ Confirmed Reason for consultation: ☐ New diagnosis ☐ Recurrent/progressive disease	Referring health care provider: Surgeon (if applicable): Primary care provider: In-patient? ☐ Yes ☐ No Hospital-specify unit: Unit phone:

Please see page 2 for required criteria

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CNS Oncology Referral Requirements

REQUIRED INFORMATION TO COMPLETE PATIENT TRIAGE

If this is an urgent consult, please page on call physician at CCMB.

1. CNS lesion

   ☐ CT brain or MRI brain within the last 8 weeks (or date ordered _____)
   MUST SPECIFY for CANCER staging on imaging requisition

   ☐ Has the patient been referred to Neurosurgery: ☐Yes OR ☐ No
   If your patient has a newly identified CNS lesion, please send a referral to Neurosurgery

NOTE: This checklist is provided as a guide and is not intended as clinical guidance