CancerCare Manitoba
ActionCancerManitoba

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

CancerCare Referral Form: General Hematology

Referral Date:

REFERRAL INSTRUCTION

- Refer Acute Leukaemia cases by phone to the on-call Leukaemia/BMT physician at Health Sciences Centre: 204-787-2071.
- 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 pages 2 and 3 of this form
- Incomplete referrals will be returned
- Patient must be aware of referral to CancerCare Manitoba

PATIENT INFORMATION

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

REFERRAL INFORMATION

Reason for referral:

☐ Anemia	☐ Leukocytosis	☐ Splenomegaly
☐ Neutropenia	☐ Thrombocytosis	☐ Bleeding
☐ Thrombocytopenia	☐ Sickle Cell Disease	☐ MGUS
☐ Pancytopenia	☐ Thalassemia	☐ Other:
☐ Polycythemia	☐ Thrombosis	

NB CCMB can no longer accept referrals for isolated high or low ferritin. For resources to manage these disorders, please visit https://blooddisordersday.com/diagnostic-algorithms/

Referring health care provider:

Primary care provider:

In-patient? ☐ Yes ☐ No

Hospital-specify unit:

Unit phone:

NB In-patient referrals for acute hematologic concerns must be communicated directly to the on call General Hematology Physician.

Please see page 2 and 3 for required criteria

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General Hematology Referral Requirements

REQUIRED INFORMATION TO COMPLETE PATIENT TRIAGE

☐ **Complete Blood Count (CBC) with differential required within 3 months of referral.**
☐ History and Physical Attached
☐ Medication List Attached
☐ Is the patient a current smoker? ____Yes ____ No

Referral-Reason Specific TESTS REQUIRED within 3 MONTHS of Referral

General Hematology Referral Reason	Requirements		
Anemia, Thrombocytopenia, Neutropenia or Pancytopenia	☐ Reticulocyte Count		
	☐ Ferritin	☐ Iron	☐ TIBC
	☐ Vitamin B12	☐ TSH	
	☐ Creatinine	☐ LDH	
	☐ ALT	☐ GGT	
	☐ Alkaline Phosphatase		
	☐ Total and Direct Bilirubin		
Sickle Cell Disease or Thalassemia ****Not required to be done within 3 months of referral****	☐ Hemoglobin Electrophoresis (Link: Hemoglobinopathy Investigation Requisition)		
Thrombocytosis	☐ Ferritin	☐ Iron	☐ TIBC
	☐ CRP		
MGUS	☐ Serum Protein Electrophoresis		
	☐ Free Light Chain Ratio		
	☐ Creatinine	☐ Calcium	
Splenomegaly	☐ Ultrasound of Abdomen (Liver and Spleen)		
	☐ Creatinine	☐ LDH	
	☐ AST	☐ ALT	
	☐ GGT	☐ Alkaline Phosphatase	
	☐ Total and Direct Bilirubin		

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Thrombosis	☐ CT or Ultrasound confirming blood clot	
Polycythemia	☐ Reticulocyte Count	
	☐ JAK2 (Link: JAK2 Requisition)	☐ Erythropoietin Level (Link: EPO Level Requisition – must write Erythropoietin Level in the additional biochemistry box)
Leukocytosis	☐ Reticulocyte Count	
	☐ CRP	
Bleeding Disorder	☐ Completed ISTH- bleeding assessment Tool: https://www1.wfh.org/docs/en/Resources/Assessment_Tools_ISTHBAT.pdf	

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