CancerCare Manitoba
ActionCancerManitoba

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

CancerCare Referral Form: Head and Neck

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:	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

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

Please see page 2 for required criteria

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Head and Neck Oncology Referral Requirements

REQUIRED INFORMATION TO COMPLETE PATIENT TRIAGE

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

1. Head and Neck Cancer
   - ☐ CT neck with last 12 weeks (Date Ordered/Completed _____)
     MUST SPECIFY for CANCER staging on imaging requisition

2. Thyroid
   - ☐ Thyroid ultrasound demonstrating a nodule (Date Completed _____)
     MUST SPECIFY for CANCER staging on imaging requisition
   - ☐ Pathology/cytology preferred (send if available)

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