CancerCare Manitoba
ActionCancerManitoba

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

CancerCare Referral Form: Lymphoma

Referral Date:

REFERRAL INSTRUCTION

- Refer Urgent Lymphoma Cases to General Hematology on call via paging
- 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

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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Lymphoma Oncology Referral Requirements

REQUIRED INFORMATION TO COMPLETE PATIENT TRIAGE

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

- ☐ Pathology Report (If available)
- ☐ CT Neck (or Date Ordered _____)
  MUST SPECIFY for CANCER staging on imaging requisition
- ☐ CT Chest (or Date Ordered _____)
  MUST SPECIFY for CANCER staging on imaging requisition
- ☐ CT Abdomen and Pelvis (or Date Ordered _____)
  MUST SPECIFY for CANCER staging on imaging requisition

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