CancerCare Manitoba
ActionCancerManitoba

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

# CancerCare Referral Form: Leukemia/BMT

Referral Date:

**REFERRAL INSTRUCTION**

- Refer Acute Leukemia cases by phone to the on-call Leukemia/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 page 2 of this form
- Incomplete referrals will be returned
- Patient must be aware of referral to CancerCare Manitoba

| **PATIENT INFORMATION** | |
|---|---|
| Surname:<br><br>Given name & initial:<br><br>Previous name(s):<br><br>Preferred name (if different from given name):<br><br>DOB:<br><br>PHIN:<br><br>Need for an interpreter? ☐ Yes ☐ No<br><br>Specify language: | Address:<br><br>City:<br><br>Postal Code:<br><br>Preferred Phone:<br><br>Emergency contact/support person name:<br><br>Relationship:<br><br>Preferred phone: |
| **REFERRAL INFORMATION** | |
| Diagnosis:<br>☐ Presumptive<br><br>☐ Confirmed<br><br>Reason for consultation:<br>☐ New diagnosis<br><br>☐ Recurrent/progressive disease | Referring health care provider:<br><br>Surgeon (if applicable):<br><br>Primary care provider:<br><br>In-patient? ☐ Yes ☐ No<br><br>Hospital-specify unit:<br><br>Unit phone: |
| Please see page 2 for required criteria | |

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# Leukemia/BMT Oncology Referral Requirements

| REQUIRED INFORMATION TO COMPLETE PATIENT TRIAGE |
|---|

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

- ☐ CBC with differential completed within the last 4 weeks.

Note: Requests for transplantation of non-hematologic conditions must be generated from the appropriate sub-specialist with documentation of expert consensus provided with the referral.

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