CancerCare Manitoba
ActionCancerManitoba

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

CancerCare Referral Form: Surgical Oncology

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	

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

Surgical Oncology Referral Requirements

REQUIRED INFORMATION TO COMPLETE PATIENT TRIAGE

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

No minimum requirements at this time.

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