CancerCare Manitoba
ActionCancerManitoba

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

CancerCare Referral Form: Thoracic

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

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Thoracic Oncology Referral Requirements

REQUIRED INFORMATION TO COMPLETE PATIENT TRIAGE

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

If your patient **does not have a biopsy for presumed lung cancer,** please send a **referral to Thoracic Surgery OR Interventional Pulmonology** for biopsy.

If your patient does not have a biopsy for **upper GI malignancy**, please send a **referral to Thoracic Surgery** for biopsy.

Referrals From Primary Care:

1. Lung cancer
   - ☐ Pathology report with cancer diagnosis (unless patient is symptomatic from tumor)
   - ☐ CT chest (Date completed_____)
     MUST SPECIFY for CANCER staging on imaging requisition
   - ☐ Patient symptoms
     - ☐ Symptomatic (including: cancer pain, hemoptysis, dyspnea from tumor compression)
     - ☐ Asymptomatic

2. Gastroesophageal & Esophageal cancer
   - ☐ Pathology report with cancer diagnosis
   - ☐ CT chest, abdomen, pelvis **OR** CT chest and PET within the last 8 weeks
     (Date Ordered_____)
     MUST SPECIFY for CANCER staging on imaging requisition

3. Thymoma/thymic carcinoma
   - ☐ Pathology report with cancer diagnosis
   - ☐ CT chest, abdomen, pelvis within the last 8 weeks (Date Ordered_____)
     MUST SPECIFY for CANCER staging on imaging requisition

4. Mesothelioma
   - ☐ Pathology report with cancer diagnosis
   - ☐ CT chest, abdomen, pelvis within the last 8 weeks (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