London Health Sciences Centre

Oncology Patient Navigation Program (OPNP) Referral Form

TEL: (519) 685-8500 ext: 56928 **Email: opnp@lhsc.on.ca** **FAX: (519) 432-1805**

PATIENT INFORMATION		Date of Referral:
First Name:	**Last Name**:	Date of Birth:
Address:	Apt. #:	City, Town, Village:
Postal Code:	Phone Number:	OHIP:
Patient Email Address:		
Translator Required: ☐ Yes ☐ No Specify Language:	Is patient aware of referral? ☐ Yes ☐ No Is the patient aware of potential cancer diagnosis? ☐ Yes ☐ No	

Please select area of concern:

☐ Lung ☐ Esophagus ☐ Gastric ☐ Head and Neck ☐ Peritoneal ☐ Sarcoma

☐ Anal ☐ Colon ☐ Rectal ☐ Liver ☐ Pancreas ☐ Biliary

For colorectal referrals please provide endoscopy report and pathology (if available).
For lung referrals please provide most recent CT thorax report (imaging must be completed in the last 3 months)**.**
For liver/pancreas/biliary referrals please provide recent CT chest abdomen and pelvis (imaging must be completed in the last 3 months)**.**
For sarcoma please provide recent ultrasound of area of concern (imaging must be completed in the last 3 months)**.**

Reason for referral/pertinent presenting symptoms:

Significant past medical history: *(Can attach Cumulative Patient Profile)*

Recent related diagnostic tests:

FAX WITH REFERRAL FORM

☐ Pertinent imaging reports ***(including CT Scan)***

☐ Blood work results within last 3 months ***(including CBC, INR/PTT, Urea, Creatine, Electrolytes)***

☐ Current list of medication

☐ Pathology/cytology results (if available)

REFERRING PHYSICIAN

Name: _____

Phone Number: _____ Fax: _____

Physician Signature: _____

FAMILY PHYSICIAN ***(if not referring physician)***

Name: _____

Phone Number: _____

Fax: _____

PLEASE INFORM ALL PATIENTS OF REFERRAL. OPNP WILL CONTACT PATIENT DIRECTLY WITH APPOINTMENT.
CPSO Please reach out to our office 48hours past to follow-up with referral
NOTE: An incomplete referral form may lead to delays in appointment booking.