London Health Sciences Centre
London Regional Cancer Program

Phone: 1-888-509-4484 (519-685-8602)
Fax: 1-888-356-8889

London Regional Cancer Program
790 Commissioners Road East
London, Ontario N6A 4L6

NEW PATIENT REFERRAL

Please complete ALL information. Fax all related reports with this request (unless within Cerner)

PATIENT INFORMATION

Name:	Sex: ☐ Male ☐ Female	Date of Referral (YYYY/MM/DD):
Address:		LRCP/LHSC Chart Number: Health Insurance Number:
Home/Cell Phone Number: ( )	Business Phone Number: ( )	Date of Birth (YYYY/MM/DD):
Patient Currently: ☐ Home ☐ Hospital Name of Hospital:		Call Appointment to: ☐ Patient ☐ Physician ☐ Hospital

REFERRAL INFORMATION (To be completed by Referring Physician)

Referring Physician Name:	Billing Number:	Phone Number: ( ) Fax Number: ( )
Family Physician Name:	Address:	Phone Number: ( )
Working Diagnosis Patient Informed of Diagnosis: ☐ Yes ☐ No		
Previous Cancer Treatment ☐ Yes ☐ No	Chemotherapy: Radiation Therapy:	Other:
Surgery (Procedure, Date, Hospital) Pathology: Diagnostic Tests (Blood Work/Imaging – Include Procedure, Date, Location)	History **Referring Physician Signature** _____ _____ Date	

LRCP FOLLOW-UP (For LRCP Office Use Only)

Clinic Appointment

Given to:
☐ Patient
☐ Physician
☐ Hospital
☐ Secretary
☐ Other (state) _____

Doctor/Service Requested

Reviewed By:_____ _____ _____
Physician Date Time

Appointment Cancelled by:	Reason:
Rebooked Appointment:	
Information Taken By:	Booked:

See Over ⟶