



PATIENT REFERRAL FORM

Referral Re-Referral (*patient previously seen at BCCA*) Date of Referral _____

_____ In order to process this referral/re-referral, a completed form with essential documentation should be directed to the Cancer Centre or Clinic* _____

For Urgent Referrals please contact an Oncologist directly at your Regional Cancer Centre.
If oncologist contacted, please provide name _____

Abbotsford Centre 604-851-4710 | Centre for Southern Interior 250-712-3900 | Fraser Valley Centre 604-930-2098
Vancouver Centre 604-877-6098 | Vancouver Island Centre 250-519-5500

HAS PATIENT BEEN INFORMED OF CANCER DIAGNOSIS? Yes No

CLINICAL/PATHOLOGICAL DIAGNOSIS _____

Name		<input type="checkbox"/> Male <input type="checkbox"/> Female	D.O.B.	
(Last Name)	(First Name)	(Initial)	(Day)	(Month) (Year)
Address				
(Street)	(City)	(Province)	(Postal Code)	
Home Phone	Work Phone	Contact/Message Phone		
PHN #		Self Pay	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Referring Physician	Phone #	Billing #		
Family Physician	Phone #	Billing #		
Consultant	Phone #	Billing #		

PROCEDURES/IMAGING RELATIVE TO CONDITION & PENDING PROCEDURES/TESTS

Operations/Procedures/Imaging	Hospital/Office	Date

SPECIAL PATIENT NEEDS/TREATMENT

<input type="checkbox"/> Needs Accommodation: (CSI/VC/VIC only)	<input type="checkbox"/> Needs Interpreter/Dialect	<input type="checkbox"/> Patient & Family Counseling Referral
Other Special Needs (<i>include sight, hearing/physical impairments, oxygen, infection control such as MRSA, latex allergy</i>)		

<input type="checkbox"/> Hospital Bed Required (<i>physician must contact BCCA oncologist</i>)	<input type="checkbox"/> Patient Currently in Facility	
	Name _____	

***ESSENTIAL REFERRAL INFORMATION:** Please fax your referral letter/pathology reports/radiology reports/patient history/related consultations and procedure reports to the appropriate Cancer Centre (*fax numbers below*). Please send additional documents as per the essential information list referred to at the BCCA website www.bccancer.bc.ca/HPI/CancerManagementGuidelines/ReferralInformation/default.htm
Forms are available at the BCCA website <http://www.bccancer.bc.ca/HPI/ReferaPatient.htm>

Please choose Centre or Clinic:

- | | | |
|---|---|-------------------|
| <input type="checkbox"/> Abbotsford Centre | Phone: 604-851-4732 or 604-851-4737 | Fax: 604-675-7204 |
| <input type="checkbox"/> Centre for the Southern Interior | Phone: 250-712-3969 or 250-712-3970 or 250-979-6622 | Fax: 250-979-4001 |
| <input type="checkbox"/> Fraser Valley Centre | Phone: 604-930-4004 or 604-930-4016 or 604-587-4301 | Fax: 604-675-7222 |
| <input type="checkbox"/> Kamloops Clinic | Phone: 250-314-2734 | Fax: 250-314-2733 |
| <input type="checkbox"/> Nanaimo Clinic | Phone: 250-716-7706 | Fax: 250-755-7676 |
| <input type="checkbox"/> Prince George Clinic | Phone: 250-565-2535 | Fax: 250-565-2500 |
| <input type="checkbox"/> Vancouver Centre | Phone: 604-877-6098 | Fax: 604-708-2005 |
| <input type="checkbox"/> Vancouver Island Centre | Phone: 250-519-5585 or 519-5586 or 519-5587 | Fax: 250-519-2001 |
| <input type="checkbox"/> Vernon Clinic | Phone: 250-558-1235 | Fax: 250-558-4113 |

Confidential Fax Warning: Documents accompanying this transmission contain confidential information intended for a specific individual and purpose. This information is private and protected by law. If you are not the intended recipient and have received this communication, please notify sender by phone. Number of pages faxed _____