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 oncologist's name _____

BC Cancer - Abbotsford 604-851-4710 | BC Cancer - Kelowna 250-712-3900 | BC Cancer - Prince George 250-645-7300 | BC Cancer - Surrey 604-930-2098 | BC Cancer - Vancouver 604-877-6098 | BC Cancer - Victoria 250-519-5500

For PATH REVIEW ONLY please complete Pathology Request Form..

If you require assistance, please call 604-877-6000 ext. 672071 (Monday to Friday 8:00am-4:00pm)

HAS PATIENT BEEN INFORMED OF CANCER DIAGNOSIS? ☐ Yes ☐ No

CLINICAL/PATHOLOGICAL DIAGNOSIS _____

Requested Specialty if known: _____

Name ☐ Male ☐ Female D.O.B. / /			
(Last Name) *(First Name)* *(Initial)*			*(Day)/(Month)/(Year)*
PHN #			Self Pay ☐ Yes ☐ No
Address			
(Street)	*(City)*	*(Province)*	*(Postal Code)*
Home Phone	Work Phone	Contact/Message Phone	
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

☐ Needs Accommodation: (CSI/VC/VIC only)	☐ Needs Interpreter/Dialect Specify: _____	☐ Patient & Family Counseling Referral Reason: _____
Other Special Needs *(include sight, hearing/physical impairments, oxygen, infection control such as MRSA, latex allergy)* _____ _____		
☐ Hospital Bed Required *(physician must contact BCCA oncologist)*	☐ 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 on the BCCA website.
Please refer to this document to determine where you need to send your referral.

Please choose Centre or Clinic:

☐ BC Cancer - Abbotsford	Phone: 604-851-4732 or 604-851-4737	Fax: 604-675-7204
☐ BC Cancer - Kelowna	Phone: 250-712-3969 or 250-712-3970 or 250-979-6622	Fax: 250-979-4001
☐ BC Cancer - Prince George	Phone: 250-645-7318 or 250-645-7320	Fax: 250-645-7371
☐ BC Cancer - Surrey	Phone: 604-930-4004 or 604-930-4016 or 604-587-4301	Fax: 604-675-7222
☐ BC Cancer - Vancouver	Phone: 604-877-6098	Fax: 604-708-2005
☐ BC Cancer - Victoria	Phone: 250-519-5585 or 519-5586 or 519-5587	Fax: 250-519-2001
☐ Kamloops Clinic	Phone: 250-314-2734	Fax: 250-314-2733
☐ Nanaimo Clinic	Phone: 250-716-7706	Fax: 250-755-7676
☐ 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 _____*