EDMONTON
COMPREHENSIVE CARE & FAMILY MEDICINE

CANADIAN CANCER CARE

110, 6925 Gateway Blvd NW
Edmonton, AB T6H 2J1
P: 780-306-5656 F: 780-306-5757

FAX COMPLETED FORMS TO 780-306-5757. REFERRALS WILL NOT BE PROCESSED IF FORM IS INCOMPLETE

	Name:		**Gender:** ☐ Male ☐ Female ☐ Other
	Address (including city & postal code):		
	Best contact phone number:		
	ULI/AHC #:	**D.O.B:**	
REFERRED BY (if different from family physician)	**Name:**	**PRAC-ID:**	**Specialty:**
	Address (including city & postal code):		
	Phone:	**Fax:**	**Email:**
FAMILY PHYSICIAN **☐ No family physician**	**Name:**	**PRAC-ID:**	
	Address (including city & postal code):		
	Phone:	**Fax:**	**Email:**

REFERRAL INFORMATION		
REASON FOR REFERRAL	☐ *Consultation & follow up/work up of abnormal findings* ☐ *Palliative care, symptom and/or pain management* ☐ *No family doctor & requiring primary care* ☐ *Procedure Request (e.g., endometrial biopsy, nasal endoscopy, lump/bump/skin lesion removal, IUD insertion)* ☐ *Cancer screening inquiries* ☐ *Post-cancer treatment follow up inquiries*	Other:
TYPE OF REFERRAL	**☐ Consultation only** **☐ Consultation & short term follow up of specific inquiries (e.g., pain management, follow up of imaging/referral, work-up of abnormal findings, procedure request)** **☐ Consultation & request to take over care**	
PATIENT MEDICAL HISTORY *If known: past medical history, surgical history, medications, allergies, family history*		

Is there any imaging that is <u>not available</u> on Netcare for our review? ☐Y ☐N
Are there any <u>pending referrals</u> for our review? ☐Y ☐N **If yes, who/when:** _____
Is the <u>patient aware</u> of this referral? ☐Y ☐N **Is the <u>family doctor aware</u> of this referral?** ☐Y ☐N ☐No family doctor

REFERRING MD SIGNATURE: _____ **DATE OF REFERRAL:** _____