Regional Systemic Therapy Network Referral

Date (yy/mm/dd) & Time: ______________________

ADDRESSOGRAPH

Regional Clinic: ______________________ Referring Oncologist: ______________________
(Print name)

Patient Diagnosis: ______________________ Primary Nurse: ______________________
(Print name)

Regimen ______________________ Weight: ______cm. Weight: ______kg. BSA: ______________

VAD: ☐ No ☐ PICC ☐ Port-a-Cath ☐ Hickman ☐ ***VAD insertion***: ______________________

Treatment **has begun** at Cancer Centre ☐ No ☐ Yes Date of last dose: ______________________

Of treatments received: ______________________

☐ Day 1 of treatment **to be given** at Cancer Centre ☐ Initial treatment orders (treatment **to begin at** Regional Clinic. ☐ Orders attached ☐ Total # of cycles planned ______________________

☐ Continue previous dose ☐ Modify dose ______________________

Return appointment booked ☐ No ☐ Yes, Date ______________________

Repeat scans, tests, etc.: ☐ No ☐ Yes, type______________________

Date ______________, Location ______________________

Supportive Care Referrals: CCAC: ☐ Other: ______________________

Regional Clinic Physician: ______________________ notified and accepted referral.
(Physician name)

Treatment **start date** at Regional clinic: ______________________.

Patient notification: ☐ Patient instructed to call clinic ☐ Clinic to contact patient

☐ Other:

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Checklist for Faxing: Referral ☐ No ☐ Yes Physician orders ☐ No ☐ Yes Patient history ☐ No ☐ Yes Drug funding information: ☐ No ☐ Yes Surgical & Pathology reports: ☐ No ☐ Yes

______________________ ______________________
Signature/Designation Print Name/Designation

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