



**ORILLIA SOLDIERS' MEMORIAL HOSPITAL  
GENETIC SERVICES - ONCOLOGY REFERRAL**

Telephone: (705) 327-9154 Fax: (705) 325-9459

Appt. Date & Time: \_\_\_\_\_

Surname: \_\_\_\_\_ First Name: \_\_\_\_\_

DOB: \_\_\_\_\_ (YY/MM/DD) MOH#: \_\_\_\_\_ Version: \_\_\_\_\_

Address & Postal Code: \_\_\_\_\_

Home Ph #: \_\_\_\_\_ Work Ph #: \_\_\_\_\_ Cell Ph #: \_\_\_\_\_

Parent or Spouse's Name: \_\_\_\_\_

Reason for referral: \_\_\_\_\_

Current health concerns: \_\_\_\_\_

Current medications: \_\_\_\_\_

Has the patient had cancer her/himself: Yes No Family history of cancer: Yes No

Family member affected with cancer	Relationship to patient (e.g. maternal/paternal)	Primary type of cancer	Age at diagnosis
1.			
2.			
3.			
4.			
5.			
6.			

Records Requested	Sent with referral?	Date requested	Date received
Pathology report for patient	Yes No N/A	_____	_____
Pathology for family member	Yes No N/A	_____	_____
Other: _____	Yes No N/A	_____	_____
Other: _____	Yes No N/A	_____	_____

Referring Source/Specialty & Billing #: \_\_\_\_\_

Address & Postal Code: \_\_\_\_\_

Telephone: \_\_\_\_\_ Inside Line: \_\_\_\_\_ Fax: \_\_\_\_\_

Family Dr.: \_\_\_\_\_

Signature & Title: \_\_\_\_\_ Date & Time: \_\_\_\_\_