



DT9422

MEDICAL ONCOLOGY CONSULTATION/ ADULT HEMATOLOGY-ONCOLOGY

Note: Refer to the clinical alerts on the back of the form and favor, if available, the protocols of the Accueil Clinique before filling it out.

Patient's first and last name			
Health insurance number	Year	Month	Expiry
Parent's first and last name			
Area code	Phone number	Area code	Phone number (alt.)
Address			
Postal code			

Reason for consultation	Clinical priority scale: A: ≤ 3 days B: ≤ 10 days C: ≤ 28 days D: ≤ 3 months E: ≤ 12 months
<ul style="list-style-type: none"> Patients with a suspected or confirmed cancer can be referred to the appropriate specialty according to local practice. Lymphomas and hematological malignancies should be referred via to the following form: HEMATOLOGY-ONCOLOGY CONSULTATION/ADULT HEMATOLOGY. 	
<input type="checkbox"/> New diagnosis of cancer – Primary site (if known): – Metastasis site(s) if known: <i>(Prerequisite: imaging (mandatory) and pathology reports (if available))</i>	B
<input type="checkbox"/> Suspected metastatic relapse in patient with known history of neoplasia and without active follow up in oncology – Primary site: – Location of prior follow up: <i>(Prerequisite: imaging (mandatory) and pathology reports (if available))</i>	B
<input type="checkbox"/> Suspicious clinical situation of neoplasia or metastasis with no primary site identified – Specify: <i>(Prerequisite: imaging (mandatory) and pathology reports (if available))</i>	B
<input type="checkbox"/> Treatment reassessment in patient without active oncology follow up (e.g. hormonal therapy)	E
<input type="checkbox"/> Other reason for consultation or clinical priority modification <i>(MANDATORY justification in the next section):</i>	Clinical priority
Suspected diagnosis and clinical information (mandatory)	If prerequisite is needed :
	<input type="checkbox"/> Available in the QHR <input type="checkbox"/> Attached to this form
Special needs:	
Referring physician identification and point of service	
Referring physician's name	Licence no.
Area code Phone no.	Extension Area code Fax no.
Name of point of service	
Signature	Date (year, month, day)
Family physician: <input type="checkbox"/> Same as referring physician <input type="checkbox"/> Patient with no family physician	
Family physician's name	Registered referral (if required) If you would like a referral for a particular physician or point of service
Name of point of service	

Clinical alerts (non-exhaustive list)**Refer the patient to the Emergency-department**

- Suspicion of medullary compression
- Malignant hypercalcemia (corrected Ca > 3 mmol/L)
- Febrile neutropenia ($T^{\circ} \geq 38,3^{\circ}\text{C}$ and neutrophils $< 1,0 \times 10^9/\text{L}$)
- Rapidly progressing neurological symptoms suspicious of SNC primary or secondary tumor
- Suspicion of superior vena cava syndrome