Santé et Services sociaux Québec

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 | Expiry Year Month

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**

- **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.**

☐ New diagnosis of cancer – Primary site (if known): _____ – Metastasis site(s) if known: _____ *(Prerequisite: imaging (mandatory) and pathology reports (if available))*	**B**
☐ Suspected metastatic relapse in patient with known history of neoplasia and without active follow up in oncology – Primary site: _____ – Location of prior follow up: _____ *(Prerequisite: imaging (mandatory) and pathology reports (if available))*	**B**
☐ Suspicious clinical situation of neoplasia or metastasis with no primary site identified – Specify: _____ *(Prerequisite: imaging (mandatory) and pathology reports (if available))*	**B**
☐ Treatment reassessment in patient without active oncology follow up (e.g. hormonal therapy)	**E**
☐ **Other reason for consultation or clinical priority modification *(MANDATORY justification in the next section)*:**	**Clinical priority**

Suspected diagnosis and clinical information (mandatory)

If prerequisite is needed :

☐ **Available in the QHR**

☐ **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)

Stamp

Family physician: ☐ **Same as referring physician** ☐ **Patient with no family physician**

Family physician's name

Name of point of service

Registered referral (if required)

If you would like a referral for a particular physician or 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° ≥ 38,3 °C and neutrophils < 1,0 X 10^9/L)
- Rapidly progressing neurological symptoms suspicious of SNC primary or secondary tumor
- Suspicion of superior vena cava syndrome