SUSPICION OF CANCER DIAGNOSTIC ASSESSMENT PROGRAM (DAP)
REFERRAL FORM

Royal Victoria Regional Health Centre
201 GEORGIAN DRIVE, BARRIE, ONTARIO L4M 6M2
Phone: (705) 728-9090 x 43144 Fax: (705) 739-5636

PATIENT INFORMATION			
Surname	First Name	Gender ☐ F ☐ M	D.O.B. (dd/mm/yyyy)
Address	City/Province	Postal Code	Phone Number
RVH V# (if applicable)	OHIP # (with version code)	Patient Email Address	
Name of Preferred Pharmacy		Family Physician	

REFERRING PHYSICIAN INFORMATION		
Referring Physician Name	Billing #	Date of Referral (dd/mm/yyyy)
Referring Physician Address	Phone #	Fax #
Referring Physician Signature		

REASON FOR CANCER SUSPICION:

*** Please note: If a referral for weight loss NYD, please include what work up has already been completed. Consider CBC, BMP, LFTs, TSH, chest x-ray, medication, and nutritional review, and ensure your patient is up to date on age and gender appropriate cancer screening as per Ontario Guidelines.

Please attach pertinent imaging and/or labs, as well as the patient's past medical history, current medications, and relevant consultation notes.

PLEASE ENSURE PATIENT IS AWARE AND ACCEPTING OF THIS REFERRAL.

PLEASE FAX COMPLETED REFERRAL FORM TO (705) 739-5636