Marsden Centre Fax In Referral Form
Please FAX form and documents to (905) 508-4827

Marsden Centre
for Excellence In Integrative Medicine

Date of referral: _____

| | | | |
|---|---|---|---|
| **Site** | ☐ Breast | ☐ Prostate | ☐ Head and Neck |
| | ☐ GI: _____ | ☐ Gynecological | ☐ CNS |
| | ☐ Lung | ☐ Genitourinary | ☐ Hematological |
| | ☐ Melanoma | ☐ Sarcoma | ☐ Other:_____ |
| **Service Required:** | ☐ Complete Naturopathic Oncology | ☐ IVIT Therapy (Please Provide Details) | |
| | ☐ Locoregional Hyperthermia | ☐ CTC Testing (Quantification) | |
| | | ☐ CTC Testing (Characterization) | |

**Patient Information:**

Last Name:_____ First Name: _____

OHIP#:_____ DOB: (DD/MM/YY):_____

Gender: M / F Does the patient speak English?: ☐ Yes ☐ No ☐ Other: _____

Address:_____ City:_____ Postal Code:_____

Home Phone:_____ Business/Cell : _____

Patient Location: ☐ Home ☐ Hospital ☐ (Specify): _____

Other contact person name & phone number: _____

**Doctor Information**

Name:_____

Phone:_____ Ext.:_____ Direct Line: _____ Fax: _____

**Patient Information and Supporting Documentation**

Date of Surgery/Biopsy (DD/MM/YY):_____ ☐ N/A

Treatment Setting: ☐ New ☐ Recurrent/Progressive ☐ Other:_____

Please note the patient remains under the care of the referring ND until seen by an ND at MCNE

Please send the following if available:

| Reports | Faxed | Pending | Imaging | Faxed | Pending |
|---|---|---|---|---|---|
| Referral History & Physical | | | Chest X-Ray | | |
| Operative Bronchoscopy | | | Other Plain Film | | |
| Pathology Reports | | | Ultrasound | | |
| X-Ray Reports | | | Bone Scan | | |
| Chemo Schedule | | | CAT Scan | | |
| Blood Work | | | Mammogram | | |
| Pulmonary function Tests | | | Receptors | | |
| | | | MRI | | |

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Phone Number: (905) 508-4498
We will contact the patient to set up an appointment date and time and then will confirm with the referring doctor date and time.

Please note: regardless of the referral type, patients will be required to have a paid consult with an ND at MCNE prior to receiving treatment.

Referring Provider Signature:_____