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
- ☐ GI: _____
- ☐ Lung
- ☐ Melanoma
- ☐ Prostate
- ☐ Gynecological
- ☐ Genitourinary
- ☐ Sarcoma
- ☐ Head and Neck
- ☐ CNS
- ☐ Hematological
- ☐ Other:_____

Service Required:

- ☐ Complete Naturopathic Oncology
- ☐ Locoregional Hyperthermia
- ☐ IVIT Therapy (Please Provide Details)
- ☐ Acupuncture & Traditional Chinese Medicine
- ☐ CTC Testing

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:_____