Date: _____
YYYY – MM - DD

Attention: Cancer Fatigue Services Inc.
Clinical Care Team
2 Sheppard Ave E, Suite 901
North York, Ontario, M2N 5Y7

Re: _____
Patient Name (First Last)

Dear Colleagues,

I am writing to refer my patient, _____, to you for further evaluation and treatment for cancer-related fatigue.

I have included demographic and clinical information that may be relevant to their care in:

❒ the space on the second page of this document and/or

❒ within an attached document.

Please do not hesitate to contact me if you have questions.

Sincerely,

[Referring Physician Information]

_____ [*Name: First, Last*]

_____ [*Name of Practice, Facility or Institution*]

_____ [*Work Address*]

_____ [*Primary Email*]

_____ [*Primary Phone*]

Referring physician's information and consent:

I am a ___ or member of a ___:

Specialist ❒ If so, please list: _____

FHO / FHT ❒ I am willing to temporarily de-roster this patient ❒

FHG / CCM ❒

REFERRING PHYSICIAN **Name:** Dr. _____ **Billing Number:** _____

Signature: _____ **Date:** _____
YYYY – MM - DD

Cancer Fatigue SERVICES

Referred Patient Information

Last: _____ **First:** _____

Sex: ❒ Female ❒ Male **DOB:** _____ _____ _____
YYYY MM DD

OHIP #: _____

Address: _____

City: _____ **Province:** _____ **Postal Code:** _____

Phone: _____ **Email:** _____

Reason for Referral

[Please provide all relevant clinic notes, procedure reports, test results, imaging, symptom timeline, etc.]

Please complete and return this referral form via fax to:

416-849-5421