Alberta Health Services

Affix patient label within this box

Palliative Radiation Oncology Referral

If you suspect **Spinal Cord Compression**, please call 780-432-8771 immediately.
Ask for the patient's Radiation Oncologist *(if known)* or the on-call Radiation Oncologist.

Previous Radiation Oncologist *(if known)* _____

Fax referral to 780-432-8681. A fax receipt will be sent when processed.

Date of Referral *(yyyy-Mon-dd)*	Referring Physician	
Referring Physician Location ☐ CCI ☐ Other* _____ *Please **fax a referral letter** with this form		Phone Number
Patient location: ☐ Home ☐ Inpatient at _____		
Mobility issues ☐ No ☐ Yes Specify _____		
Translator Required? ☐ No ☐ Yes Specify language _____		

Referral Criteria ***(All criteria must be met)***	
☐	Biopsy proven malignancy ? *(If no biopsy, please call on-call Radiation Oncologist to discuss)*
☐	Patient aware of diagnosis?
☐	Recent relevant imaging? *(Less than 6 months for bone metastases; less than 1 month for brain metastases) If imaging not on Netcare, please attach relevant reports/CD with images*
☐	Can patient remain still and lie flat? *(Necessary for radiation treatment)*
☐	Screening for Distress form completed and attached? http://www.albertahealthservices.ca/frm-18125.pdf

Diagnosis

Primary _____

Metastatic to where? _____

Reason for Referral (*Please check all applicable)*

☐ Painful bone metastases (*Specify where)* _____

Current medications *(opioids, steroids, etc).* _____

☐ Brain metastases Seizures ☐ No ☐ Yes

Current medications *(anti-epileptics, steroids, etc.)* _____

☐ Other *(Specify)* _____