THE HEAD & NECK CLINIC
Alberta Head & Neck Centre *for* Oncology and Reconstruction

# New Patient Referral:

Patient Name: _____ AHC Number: _____

DOB: ____ (mm) ____ (dd) ____ (yyyy) Phone Number: _____

Urgency of Consultation: *Please check one*
◯ Urgent (1-2 weeks) ◯ Semi-urgent (2-4 weeks) ◯ Normal (4-6 weeks)

◯ Thyroid/Parathyroid ◯ Other head and neck

Cancer: *Please check one*
◯ Confirmed ◯ Possible ◯ Unknown

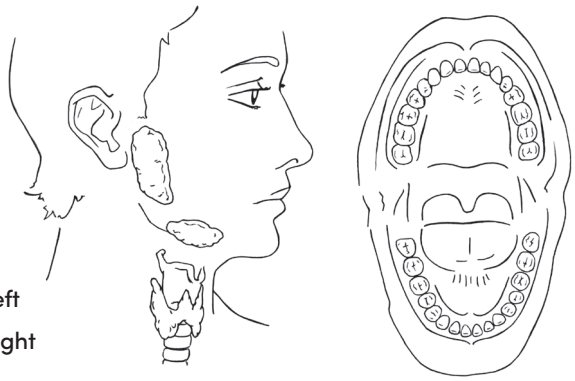
Check all that apply below:

Risk Factors:
- ◯ Smoking
- ◯ Prolonged alcohol use
- ◯ Previous head and neck cancer
- ◯ Previous head and neck irradiation

Symptoms and Signs:
- ◯ Persistent throat pain
- ◯ Non-healing mouth or pharynx ulcer
- ◯ Hoarseness
- ◯ Dysphagia or odynophagia
- ◯ Neck Mass
- ◯ Hemoptysis
- ◯ Oral or pharyngeal mass or change in denture fit

Reason for Referral:

Please circle or label area(s) of concern on the below:



◯ Left
◯ Right

Duration of Symptoms: ____ (weeks) ____ (months)

Name of Doctor Referring: _____

PracID: _____

Date: ____ (mm) ____ (dd) ____ (yyyy)

Signature: _____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