



New Patient Referral:

Patient Name:

AHC Number:

DOB:
mm dd yyyy

Phone Number:

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

Thyroid/Parathyroid Other head and neck

Cancer: Confirmed Possible Unknown
Please check one

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
- Hoarseness
- Neck Mass
- Oral or pharyngeal mass or change in denture fit
- Non-healing mouth or pharynx ulcer
- Dysphagia or odynophagia
- Hemoptysis

Reason for Referral:

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

Duration of Symptoms:
weeks months



- Left
- Right

Name of Doctor Referring:

PracID:

Date:
mm dd yyyy

Signature: _____