Fondation du cancer de Gaspé
Gaspé Cancer Foundation

REFERRAL FORM

We certify that Mr. / Ms. _____ is referred to

☐ Chandler ☐ Rimouski ☐ Québec ☐ Montréal ☐ Sherbrooke ☐ Other
☐ St. Anne des Monts ☐ Rivière-du-Loup

Reason for referral: ☐ Specialized consultation ☐ Specialized investigation
☐ Specialized treatment

Referring physician: _____
(Please print)

_____ _____
Signature **Date**

We certify that Mr. / Ms. _____ was present

for an appointment at our establishment on _____ (**Date)**

Location:

☐ Chandler ☐ Rimouski ☐ Québec ☐ Montréal ☐ Sherbrooke
☐ St. Anne des Monts ☐ Rivière-du-Loup

Reason for consultation: ☐ Radiation therapy ☐ Chimotherapy ☐ Surgery
☐ Nuclear scan ☐ Follow-up

Physician consulted: _____
(Please print)

_____ _____
Signature **Date**

Office use only:

Membership # _____ Expiry date of membership card _____

Cheque # _____ Beginning date of treatment _____

Gaspé Cancer Foundation, P.O. Box 6078, Gaspé (Québec) G4X 2R6