# ONCOLOGY REFERRAL COVER LETTER

**Date:**
**Urgency:** [ ] Routine [ ] Urgent [ ] Suspicion of Cancer (2WW)

## RECIPIENT INFORMATION

**Attending Oncologist:**
**Facility/Hospital:**
**Department:**

## PATIENT DEMOGRAPHICS

**Full Name:**
**Date of Birth:**
**Patient ID/MRN:**
**Contact Number:**

## CLINICAL INDICATIONS

**Primary Diagnosis / Reason for Referral:**

**Relevant Medical History & Comorbidities:**

## DIAGNOSTIC SUMMARY

**Biopsy Results:**
**Imaging (CT/MRI/PET):**
**Tumor Markers:**
**TNM Staging (if known):**

**Referring Provider:** _____

**Provider Name:**
**Practice Name:**
**Contact Phone:**