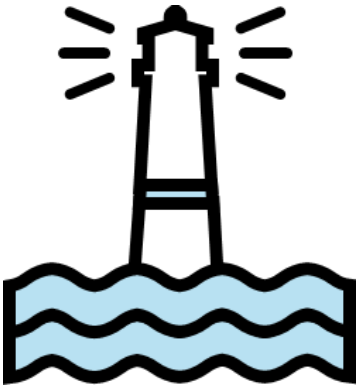

Suspicion of Cancer Service Model

Clinical Guidance

JUNE 2026

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Ontario Health

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Introduction

Purpose

This document provides standardized, province-informed clinical guidance to support implementation of the Suspicion of Cancer (SoC) Service Model. The guidance is informed by available evidence and expert clinical consensus available at the time of writing and is intended to help referring clinicians and SoC Service Teams. This document is also designed as a pilot-ready package to support Cohort 1 onboarding and usability testing, with content expected to be refined based on implementation feedback and evaluation findings. In addition to defining clinical scope and pathways, this document outlines minimum pilot-ready service expectations for referral review, communication, navigation, and safety escalation to support timely, consistent, and safe implementation across Cohort 1 sites.

Intended Audience

- Referring clinicians (primary care, walk-in/urgent care, emergency department (ED))
- SoC Service Teams (clinical, navigation, administrative, and operational roles)
- Regional Cancer Program leaders and disease-site partners

Suspicion of Cancer: Definition and Key Concepts

Definition

SoC is present when persistent (more than 4 weeks), progressive, or unexplained symptoms, in combination with early abnormalities identified through initial investigations, give rise to clinical concern for an underlying malignancy after common non-malignant causes (e.g., infection, exacerbation of pre-existing conditions, or conditions related to a patient's lifestyle or risk factors) have been reasonably considered and initial investigations completed to begin to rule these out. This determination is informed by the clinician's overall clinical assessment and judgment, including situations where clinical concern remains high despite non-specific or indeterminate findings. Other key concepts are defined in **Table 1.**

Scope & Key Principles

This guidance is symptom-driven and cancer-focused and is not a complete diagnostic workup for all causes of a presentation. Clinical judgement remains paramount. Core principles:

- *Safety first:* If clinical status is concerning at any point, direct to ED, as appropriate. The SoC Service does not replace immediate or very urgent assessment, intervention and/or diagnostic testing.
- *Timely action:* Referral review, communication, and navigation should occur within defined service expectations to reduce diagnostic delay and prevent loss to follow-up.
- *Right care, right place*: The intent is not to replace services that are working well, but to leverage existing disease-site pathways/specialties and fill gaps for patients who do not currently access timely diagnostics.
- *Standardization with flexibility:* The guidance defines a province-informed minimum standard approach while recognizing regional variation in diagnostic pathways, local infrastructure, access to investigations, and specialty services. Clinicians should refer to Regional Cancer Program guidance for additional region-specific information.
- *Equity and access:* Guidance should be applied in a way that supports equitable access, including for unattached patients, Indigenous, and equity-deserving communities.

Out of Scope

These presentations should not enter the SoC Service:

- Presentations requiring immediate or very urgent assessment or investigation **(Table 2).**
- Presentations with clearly identified non-cancer explanations or stable known diagnoses where cancer suspicion is not clinically supported
- Requests for access to cancer screening in asymptomatic individuals, without concerning symptoms or abnormal findings, which should be managed through appropriate organized screening programs
- Patients already appropriately embedded in an active disease-site pathway or Diagnostic Assessment Program (DAP), with timely access and clear diagnostic ownership

Table 1: Key Concepts

Concept	Description
Tier 1 Investigations	Tier 1 investigations help determine whether a clinical presentation raises concern for possible cancer and support initial routing to the most appropriate entry point (SoC Service, Diagnostic Assessment Program [DAP], or specialty). These investigations are typically basic, routinely available tests, such as blood work (e.g., CBC, renal and liver function tests), urinalysis, chest X-ray, and ultrasound. Tier 1 investigations support safe triage and urgency assignment but should not delay referral if they cannot be completed in a timely or feasible manner. If more definitive or context-appropriate investigations have already been completed as part of the patient's care (e.g., CT abdomen/pelvis performed in the ED), corresponding Tier 1 investigations are not required.
Tier 2 Investigations	Tier 2 investigations provide additional information to clarify likely diagnostic direction and support more definitive routing. They are not required prior to referral and are often coordinated by the SoC Service or informed by specialty input. These investigations are typically more resource-intensive, may involve longer wait times, and should be ordered selectively based on clinical context and findings that emerge during assessment (e.g., abnormal blood work, suspicious imaging, progressive symptoms, or specialist recommendations).
Tumour Markers	Tumour markers are not recommended as routine screening tests for patients with non-specific symptoms. They should be ordered selectively, only when clinical findings and/or imaging suggest a likely organ-specific primary and the result is expected to change the next diagnostic step (e.g., routing, biopsy strategy, or specialty referral). Further guidance provided in **Appendix A**.
Entry Criteria	Entry criteria support clinicians in identifying when a patient should transition from non-specific assessment into a structured diagnostic pathway. Criteria are based on symptom patterns, early investigation findings, access or follow-up risk, and clinical judgment, and are intended to support consistent triage and appropriate pathway entry.
Exit Criteria	Exit criteria guide where the patient should transition once diagnostic direction becomes clearer. This may include confirmed cancer, findings highly suggestive of a specific cancer requiring specialty workup, identification of a serious non-cancer diagnosis, or establishment of a clear follow-up plan outside the SoC Service. Tier 2 investigations may support Exit decisions by clarifying diagnostic direction; however, Exit is determined by pathway appropriateness and explicit transfer of diagnostic ownership, not by completion of a fixed set of tests.

Table 2: Immediate or Very Urgent Presentations (Illustrative Examples)

Immediate	Very Urgent
Requires assessment or investigation **within hours** due to high risk of rapid deterioration or significant clinical harm → **ED.**	Requires assessment or investigation **within 48 hours** due to risk of deterioration or significant clinical harm → **ED /Urgent Specialty Care**.
Neurologic (Red Flags[1]): • Acute spinal cord compression with rapid onset deficits • First-time seizure • Acute focal deficits (weakness, aphasia, ataxia) • Signs of raised intracranial pressure (vomiting, confusion, papilledema) **Hematologic/Metabolic:** • Suspected acute leukemia from available results with symptoms • Hyperleukocytosis with symptoms • Severe cytopenias with instability • Myeloma with end-organ damage (hypercalcemia, AKI, unstable lytic fractures) **Sepsis/Systemic:** • Suspected sepsis (including malignant source) • Hemodynamic instability **Head and Neck/Thoracic /Airway:** • Severe super vena cava syndrome with compromise • Acute airway/pharyngeal/esophageal obstruction • Hemoptysis associated with hemodynamic/respiratory instability **Gastrointestinal/Abdominal:** • Peritonitis/Perforated viscus • Complete bowel obstruction with instability • Gastrointestinal bleeding with hemodynamic compromise **Vascular:** • Uncontrolled bleeding • Acute thrombosis with ischemia • Pathologic fracture with neurovascular compromise.	**Neurologic (Orange Flags[1]):** • New severe or progressive headache without diagnostic pattern • Exertional or Valsalva-related headache • Headache with vomiting • Rapid increase in headache frequency or severity • New headache age >50 yrs • Headache waking patient from sleep • Severe, persistent headache with history of cancer (remote or recent) • New or rapidly worsening personality or behavioural change • Mild confusion **Rapid Symptom Escalation:** • Large/rapidly progressive pleural effusion with dyspnea at rest or hypoxia **Head and Neck / Thoracic / Airway:** • Progressive dysphagia with weight loss, aspiration, or inability to maintain adequate oral intake • New or rapidly worsening hoarseness with concerning associated features (e.g., neck mass, stridor, airway symptoms) **High-Risk Clinical Findings:** • Rapidly enlarging mass (breast, lymph node, thyroid, soft tissue) with significant symptoms (ongoing significant bleeding, sepsis) requiring urgent evaluation • Rapid onset B-symptom lymphadenopathy • Central lung mass with impending airway compromise **Severe Symptom Burden:** • Persistent vomiting with dehydration • Severe pain not responding to opioids **High-Risk Labs/ Imaging:** • Symptomatic hypercalcemia (confusion, constipation) **Time-Sensitive Procedures:** • Moderate-large ascites with worsening symptoms or early respiratory compromise

[1] **Kernick D, Stapley S, Hamilton W.** "Imaging patients with suspected brain tumour: guidance for primary care." *Br J Gen Pract*. 2008 Dec;58(557):880-5. doi: 10.3399/bjgp08X376203.

Guidance for Referring Clinicians

1. Confirm Presentation Scope

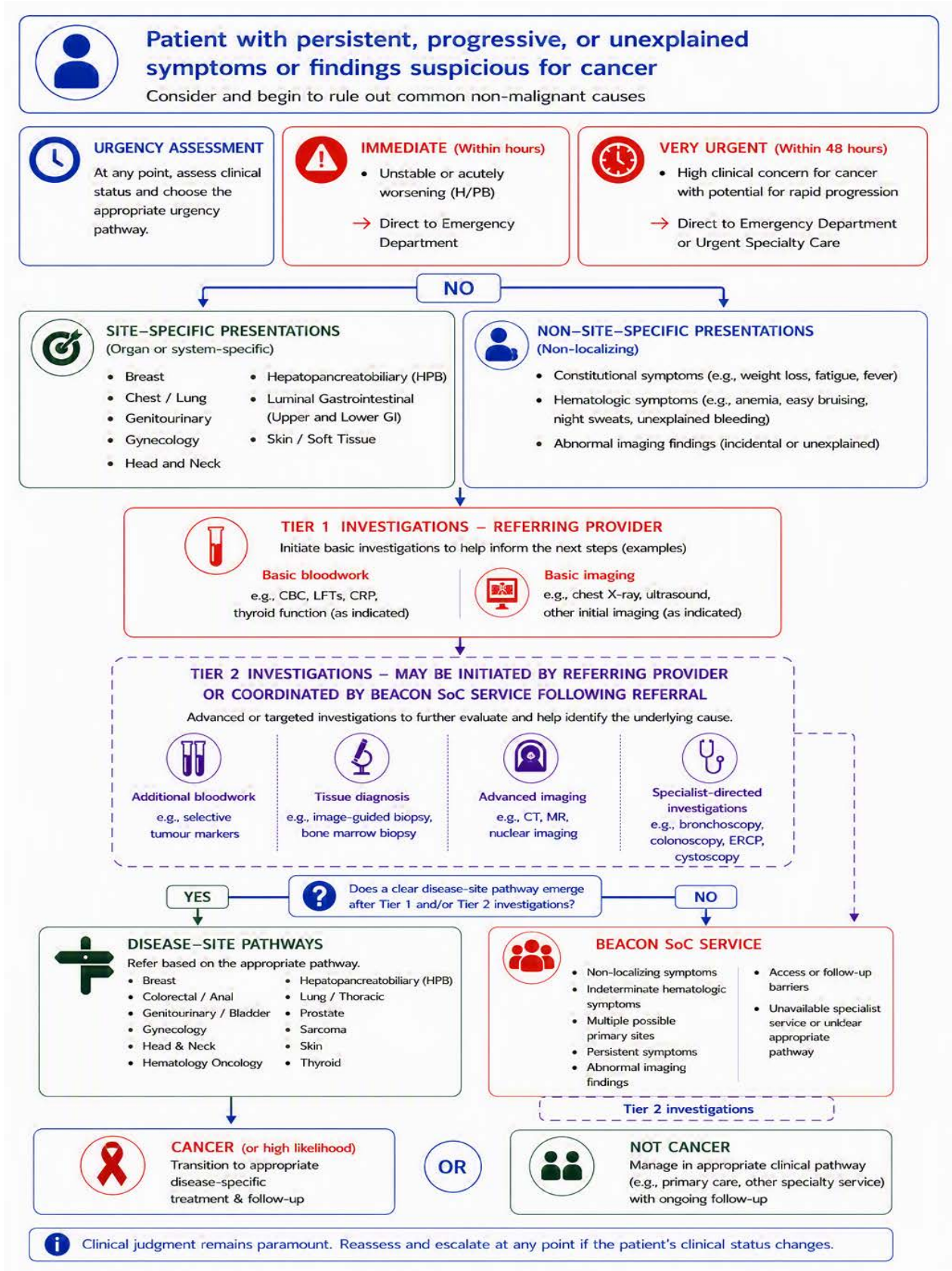
For presentations that do not require Immediate or Very Urgent assessment **(Table 2)**, determine whether referral to the SoC Service is appropriate. Refer to the SoC Service when there is clinical concern for malignancy (or another serious diagnosis) and no clear or reliable pathway for timely diagnostic progression, including:

- **Diagnostic pattern is unclear or non-specific**
    - Symptoms do not clearly localize to a single disease site
    - Symptoms involve multiple possible disease sites
    - Symptoms are systemic in nature, including constitutional features
    - Symptoms are hematologic in nature
    - Symptoms are evolving or do not yet meet clear disease-site pathway thresholds
- **Presentation resembles a disease-site pattern but does not clearly meet pathway thresholds**
    - One or more of the following apply:
    - Local pathway criteria are not fully met
    - Findings are indeterminate
    - It is unclear which specialty, or pathway should manage the diagnostic work-up
- **Imaging or test findings raise concern but lack clear pathway ownership**
    - Indeterminate or suspicious imaging findings
    - Incidental findings without a documented or actionable follow-up plan
    - Findings that do not align with an existing DAP
- **Access, coordination, or follow-up risks are present**
    - No clearly identified Most Responsible Provider (MRP) to act on results
    - Patient is unattached to primary care
    - Significant financial, social, geographic, logistical, or system navigation barriers
    - Concern the patient may be lost to follow-up
    - Initial presentation occurred in the ED, the patient does not meet criteria for admission, and timely outpatient follow-up or coordination of additional investigations is required

2. Complete Tier 1 Investigations, Where Feasible

The SoC Service is intended for patients with persistent, progressive, or unexplained symptoms suspicious for cancer where the most appropriate disease-site pathway remains unclear, multiple diagnostic possibilities exist, or no established pathway is readily accessible. Where findings clearly suggest a specific disease site or malignancy (e.g., breast, lung, gynecologic, gastrointestinal, head and neck, or hematologic malignancy), referral to the appropriate disease-site pathway, Diagnostic Assessment Program (DAP), Rapid Diagnostic Unit (RDU), or specialty service should be considered first. Referral to the SoC Service may be made prior to completion of Tier 1 investigations when patient-specific factors limit timely access to testing or reliable follow-up. Where barriers, complexity, or uncertainty exist, discussion with a BEACON/ SoC team member is encouraged to support appropriate diagnostic planning and coordination, including situations where:

- Investigations are not available locally (e.g., remote or resource-limited settings)
- Delays in access would result in clinically significant wait times
- The patient is unable to attend or complete testing (e.g., transportation barriers, frailty, or competing health or social needs)
- Appropriate follow-up cannot be ensured after testing


Patient with persistent, progressive, or unexplained symptoms or findings suspicious for cancer
Consider and begin to rule out common non-malignant causes
URGENCY ASSESSMENT
At any point, assess clinical status and choose the appropriate urgency pathway.
IMMEDIATE (Within hours)
Unstable or acutely worsening (H/PB)
→ Direct to Emergency Department
VERY URGENT (Within 48 hours)
High clinical concern for cancer with potential for rapid progression
→ Direct to Emergency Department or Urgent Specialty Care
NO
SITE–SPECIFIC PRESENTATIONS
(Organ or system-specific)
Breast
Chest / Lung
Genitourinary
Gynecology
Head and Neck
Hepatopancreatobiliary (HPB)
Luminal Gastrointestinal (Upper and Lower GI)
Skin / Soft Tissue
NON–SITE–SPECIFIC PRESENTATIONS
(Non-localizing)
Constitutional symptoms (e.g., weight loss, fatigue, fever)
Hematologic symptoms (e.g., anemia, easy bruising, night sweats, unexplained bleeding)
Abnormal imaging findings (incidental or unexplained)
TIER 1 INVESTIGATIONS – REFERRING PROVIDER
Initiate basic investigations to help inform the next steps (examples)
Basic bloodwork
e.g., CBC, LFTs, CRP, thyroid function (as indicated)
Basic imaging
e.g., chest X-ray, ultrasound, other initial imaging (as indicated)
TIER 2 INVESTIGATIONS – MAY BE INITIATED BY REFERRING PROVIDER OR COORDINATED BY BEACON SoC SERVICE FOLLOWING REFERRAL
Advanced or targeted investigations to further evaluate and help identify the underlying cause.
Additional bloodwork
e.g., selective tumour markers
Tissue diagnosis
e.g., image-guided biopsy, bone marrow biopsy
Advanced imaging
e.g., CT, MR, nuclear imaging
Specialist-directed investigations
e.g., bronchoscopy, colonoscopy, ERCP, cystoscopy
YES
Does a clear disease-site pathway emerge after Tier 1 and/or Tier 2 investigations?
NO
DISEASE–SITE PATHWAYS
Refer based on the appropriate pathway.
Breast
Colorectal / Anal
Genitourinary / Bladder
Gynecology
Head & Neck
Hematology Oncology
Hepatopancreatobiliary (HPB)
Lung / Thoracic
Prostate
Sarcoma
Skin
Thyroid
BEACON SoC SERVICE
Non-localizing symptoms
Indeterminate hematologic symptoms
Multiple possible primary sites
Persistent symptoms
Abnormal imaging findings
Access or follow-up barriers
Unavailable specialist service or unclear appropriate pathway
Tier 2 investigations
CANCER (or high likelihood)
Transition to appropriate disease-specific treatment & follow-up
OR
NOT CANCER
Manage in appropriate clinical pathway (e.g., primary care, other specialty service) with ongoing follow-up
Clinical judgment remains paramount. Reassess and escalate at any point if the patient's clinical status changes.

3. Indicate Expected Pace of Assessment

Based on clinical judgment, determine the expected pace of diagnostic assessment. All referrals for suspected cancer should be considered clinically urgent and require timely progression through diagnostic work-up. However, within this group, certain clinical features may indicate a need for more accelerated assessment.

An **Urgent Cancer Workup** pace (target investigations completed within 7-14 business days) should be selected when there is increased risk of progression, clinical deterioration, or loss to follow-up. Features that may increase urgency include rapid symptom onset, significant symptom progression, objective evidence of advanced disease, or escalating clinical instability.

In the absence of such features, a **Standard Cancer Workup** pace remains time-sensitive but may follow usual expedited cancer diagnostic timelines.

4. Complete and Submit the e-Referral Form

Submit the SoC e-Referral (Appendix B when available) without delay when clinically indicated. Complete all required fields to minimize downstream delays and avoid follow-up clarification.

4.1 Emergency Department Referrals - Patient Information at Discharge

For patients referred to the SoC Service from the ED and discharged prior to SoC contact, the referring ED clinician should provide the patient with clear written information at discharge. This information supports safe transition from acute care to outpatient diagnostic coordination and reduces the risk of loss to follow-up.

At a minimum, the information should include:

- confirmation that a referral to the SoC Service has been submitted,
- a brief explanation of the role of the SoC Service (diagnostic coordination and routing to the first appropriate service or specialty),
- the expected timeframe for initial SoC contact (typically within 48 business hours),
- how to contact the SoC Service if they have not been contacted within that timeframe, and
- clear safety-net instructions, including when to return to the ED if symptoms worsen or new urgent symptoms develop.

This information may be provided using a standardized one-page handout developed by the SoC Service and made available for use in ED.

5. After Submission

Once a referral is submitted to the SoC Service, the referring clinician, and, where appropriate, the patient, particularly in situations where ongoing follow-up through the referring source may be limited (e.g., emergency department), will receive clear communication regarding next steps.

5.1 Communication Following Submission

The SoC Service will communicate with the referring clinician when:

- the referral is **accepted** into the SoC Service,
- the referral is **not accepted** and an alternative pathway or specialty is recommended, including:
    - the clinical rationale for the recommendation, and, and
    - the first appropriate next step in care for the referring clinician to initiate, or

- **additional information or clarification** is required to support safe triage, diagnostic planning, or coordination, particularly where the patient has an established relationship with an ongoing care provider.

5.2 When Additional Work-Up Is Needed

Referrals that are incomplete should not be accepted or registered to the SoC Service. Requests for additional information or investigations should be directed to the referring clinician for completion and resubmission.
Depending on the clinical scenario, the SoC Service may:

- request targeted additional information or investigations from the referring clinician prior to acceptance, where this can be safely and efficiently completed, or
- accept the referral and coordinate outstanding work-up, when delay would increase the risk of harm, diagnostic delay, or loss to follow-up.
- accept the referral and coordinate outstanding work-up, when delay would increase the risk of harm, diagnostic delay, or loss to follow-up

When additional information or investigations are required:

- the SoC Service will communicate clearly and specifically what is needed and why,
- any follow-up action required from the referring clinician will be explicitly outlined, and
- responsibility for interim care and follow-up will be clearly articulated until diagnostic ownership is transferred.

5.3 Direct Transition to Another Pathway or Specialty Within SoC Scope

In some cases, referral review may indicate that the patient is better served through a disease-site-specific pathway or another specialty.
In these situations, the SoC Service may:

- route the patient directly to the most appropriate pathway or specialty, and
- either:
    - keep the SoC referral open during the transition to support navigation and continuity, or
    - close the SoC referral following successful onward referral, once diagnostic ownership is clearly assumed.

5.4 Escalation of Care

If urgent or concerning findings emerge at any point during review or coordination, the SoC Service will:

- escalate care immediately to the appropriate setting (e.g., ED or urgent specialty care), and
- communicate clearly with the referring clinician and receiving service to ensure continuity and safety.

5.5 Referral Non-Acceptance or Redirection Outside SoC Scope

Referral non-acceptance is uncommon and occurs only when:

- the presentation is clearly out of scope for the SoC Service, and
- there is no appropriate diagnostic or navigational role for SoC involvement.

If a referral is not accepted:

- the SoC Service will communicate this to the referring clinician,
- the reason for non-acceptance will be explained,
- clear guidance will be provided regarding the most appropriate next step, pathway, or service, where applicable, and where appropriate, the SoC Service may facilitate direct redirection or communication with the patient to support

Guidance for Suspicion of Cancer Service Teams

To support safe and consistent implementation across pilot sites, minimum service expectations are outlined below. The sections that follow describe how these expectations are operationalized in practice, allowing for local workflow variation while maintaining core clinical and safety standards.

Minimum Service Expectations (Cohort 1)

Table 3: Turnaround Time Expectations

All timeframes refer to business hours and business days (Monday-Friday, excluding statutory holidays), unless otherwise specified.

Process Interval	Clinically Acceptable Range	Rationale
Referral receipt to initial review	Same business day	Early review prevents unsafe backlogs, enables rapid identification of high-risk features, and ensures timely safety screening and appropriate routing at the point of entry. This expectation assumes clerical intake capacity is available on all business days to receive, log, and route referrals for review.
Referral receipt to first patient contact	Risk-aligned; typically within 1-2 business days for standard presentations, and sooner when there is elevated risk of harm from delay	Early patient contact supports safety-netting, confirms symptom evolution, identifies access or equity-related needs, and initiates navigation even when diagnostic testing cannot begin immediately.
Referral receipt to redirect decision (ED or specialty)	Immediate/same business day for ED-level findings; otherwise within 1-2 business days	Prompt redirection avoids holding referrals that require emergency or specialty-specific management and ensures patients are routed to the first appropriate service without unnecessary delay.
Triage decision to ED redirection	Immediate (same business day)	Patient safety overrides pathway consideration. Emergent findings require immediate escalation regardless of referral intent or pathway stage.
Triage decision to DAP or specialty redirection	Within 1-2 business days	Timely redirection maintains continuity of care, minimizes diagnostic duplication, and prevents unnecessary escalation through the SoC pathway when a disease-site-specific service is more appropriate.
SoC intake (clinical acceptance + ownership) to initiation of diagnostic workup	Risk-aligned; sooner when the potential for harm from delay is higher	Prevents avoidable diagnostic delay by anchoring initiation to the documented clinical decision to proceed with the first diagnostic investigation, rather than test booking or completion alone. At the point of SoC intake, a standardized notification may be sent to the referring provider confirming acceptance of the referral, consistent with CPSO principles of continuity of care and shared clinical accountability.
Initiation of diagnostic workup (decision to test) to completion	Variable: dependent on investigations required	Not all delays are harmful. Diagnostic completion depends on the type, sequencing, and availability of investigations; escalation should be based on clinical trajectory, evolving findings, and patient risk rather than elapsed time alone.
Initiation of diagnostic workup to exit/onward referral	Target: within 4 weeks for most patients, recognizing variability based on clinical complexity, investigation requirements, and system capacity	Exit is defined as the transfer of diagnostic ownership to another provider or service, marking the transition out of the SoC Service Exit is based on clarity of diagnostic direction and clinical ownership, rather than completion of all investigations. The SoC Service aims to establish diagnostic direction and transition care within approximately 4 weeks for most patients, with earlier exit when appropriate.

Process Interval	Clinically Acceptable Range	Rationale
		Earlier exit is expected when diagnostic direction becomes clear sooner, while longer intervals may be appropriate for complex or evolving presentations. Standardized exit categories include: • Transfer to Diagnostic Assessment Program (DAP) • Transfer to specialist care (non-DAP) • Transfer to primary care with a defined diagnostic plan • Transfer to another appropriate specialty service (e.g., rheumatology) • No further diagnostic work-up required For each exit, document: • the receiving provider or service • key clinical findings and relevant investigations • clear next steps, including any outstanding investigations and responsible provider • confirmation of transfer of clinical ownership

Table 4. Immediate & Very Urgent Redirects

Decision Trigger	Required Action and Communication
What triggers an Immediate or Very Urgent redirect?	Identification of ED-level urgency or a high risk of rapid clinical deterioration based on presenting symptoms, investigation results, or clinical judgment. Triggers may arise at any point in the SoC pathway and supersede pathway timelines.
Required disposition	Patients meeting Immediate or Very Urgent criteria must be directed to the ED for urgent assessment. The SoC Service does not replace ED care and must not introduce delay in high-risk situations.
Mandatory phone handoff	A direct, real-time phone handoff to the receiving ED is required when immediate or very urgent presentations are identified or when any delay in care could reasonably result in patient harm. Asynchronous communication alone is insufficient. This handoff should be completed by the Most Responsible Provider (MRP), with support from the SoC team as needed (e.g., facilitating contact or coordinating communication). Patients should also be advised to proceed to the ED, with clear guidance on urgency and next steps.
Is fax or electronic notification sufficient?	No. Fax or electronic notification may support documentation but does not replace a mandatory verbal handoff for Immediate or Very Urgent cases.
Who must be informed?	• The patient • The receiving ED • The referring provider (where feasible). *Notification of the referring provider does not replace the required ED handoff.*
ED considerations	Where the patient is clinically stable and without delaying care, the SoC Service may provide guidance on a preferred ED based on suspected cancer type or available specialty services (e.g., HPB service). This guidance is optional and must not delay ED presentation.
Documentation required	Document urgency rationale, communication method and timing, individuals contacted, and confirmation that the patient was directed to the ED.

Decision Trigger	Required Action and Communication
Does SoC involvement end after ED redirect?	No. SoC navigation may continue to support coordination and follow-up in the background until diagnostic ownership is clearly established. **Note:** ED redirection follows existing regional and hospital processes and does not replace ED triage or patient distribution systems. SoC does not direct patients between EDs, but supports coordination, communication, and continuity of care.

Table 5. Diagnostic Assessment Program or Specialty Redirects

Decision Trigger	Expected Action & Communication
Acceptable timeframe for non-urgent redirect decisions	Within 1-2 business days of referral review to avoid unnecessary pathway holding and to support timely redirection to the most appropriate service.
Required information for a safe handoff	Clear documentation of the rationale for redirection, relevant clinical context, the recommended pathway or service, investigations completed and pending, and a clear statement of the next expected step in care. This information should accompany the referral (forwarded or newly completed, as required) to support continuity and avoid duplication.
Referral process at handoff	Where feasible, the existing referral should be used to support continuity of care (e.g., forwarding or adapting the initial referral with updated clinical information), rather than requiring a new referral. In cases where the receiving service requires a program-specific referral (e.g., DAP intake requirements), the SoC team may support completion or coordination of the required referral to avoid delays.
Single versus multiple pathway recommendations	A single recommended pathway is preferred to support clarity and accountability; multiple options may be provided when clinically appropriate or when further information is required to determine the optimal route.
Level of explanation required	Concise and proportional to the clinical complexity. Extensive narrative is not required; documentation should be sufficient to support understanding, continuity, and clinical decision-making.
Mandatory phone handoff	Not required for non-urgent redirects, provided the receiving service has sufficient information to safely assume care.
Patient notification	Required when redirection results in a change to the anticipated care pathway, timing, or patient expectations, to support transparency and person-centred care.

Documentation and Medical-Legal Safety (Applies to All Redirects)

Redirect decisions must be documented in the patient record to support continuity, accountability, and medico-legal safety. Until a referral is formally accepted by a receiving service (SoC or other) or the patient is successfully redirected with confirmation of clinical ownership, the referring provider retains responsibility for the patient's ongoing care, consistent with CPSO principles related to continuity of care and safe handover.

At a minimum, documentation should include:

- Urgency assessment
- Rationale for redirection
- Communication method(s) used (e.g., electronic, phone)
- Receiving service (central referral or specific physician) or recommended pathway

Operational Navigation Model

The Suspicion of Cancer (SoC) Service applies a proportionate navigation model, where the intensity of SoC involvement may differ depending on clinical risk, diagnostic complexity, and barriers affecting the patient's ability to progress safely through the diagnostic pathway. This approach allows the SoC Service to provide the minimum level of intervention necessary to maintain safety, continuity of care, and diagnostic momentum, while reserving higher-intensity navigation for patients who require greater coordination or are at risk of delay or loss to follow-up. Navigation intensity may change over time as new clinical information becomes available, investigations progress, or patient circumstances evolve. Three broad levels of SoC service intensity are recognized.

Level 1: Provider-Facing Consultative Guidance

Level 1 support occurs when the SoC Service provides advisory guidance to referring clinicians without assuming patient intake or diagnostic ownership. At this level, the SoC Service functions primarily as a provider-facing navigation resource, helping clinicians determine appropriate next steps in situations where cancer may be suspected but the appropriate pathway or urgency is uncertain.

Examples include situations where:

- symptoms are non-specific, evolving, or borderline for SoC referral criteria
- clinicians are uncertain about appropriate Tier 1 investigations or sequencing
- the most appropriate diagnostic or specialty pathway is unclear
- the patient is unattached or at risk of loss to follow-up
- clinicians wish to avoid unnecessary ED referral but require system navigation support

Provider-facing support may include:

- clarification of SoC scope and referral eligibility
- guidance on urgency thresholds and escalation considerations
- advice regarding minimum diagnostic work-up
- identification of appropriate diagnostic pathways or specialty services
- discussion of navigation considerations for complex or unattached patients

Level 1 support does not include diagnostic assessment, interpretation of investigations, replacement of specialist consultation or emergency department decision-making, or assumption of ongoing clinical responsibility. At this stage, the referring clinician remains responsible for patient care and investigation decisions.

Level 2 Support: Coordinated Routing and Access Facilitation

Level 2 support involves time-limited coordination to facilitate appropriate referral routing or access to diagnostic services, without full SoC intake or longitudinal navigation. This level of involvement may be required when limited coordination is necessary to ensure safe and timely progression to the most appropriate service.

Examples include situations where:

- referral documentation requires clarification or completion
- a receiving service requires additional investigations, and coordination is needed to facilitate timely completion or identify an alternative pathway
- prerequisite investigations must be coordinated to allow referral acceptance
- access barriers prevent timely referral to the appropriate program or specialty
- the appropriate pathway requires coordination across multiple services

Level 2 activities may include:

- confirming the appropriate diagnostic or specialty pathway
- facilitating referral submission or acceptance
- facilitating access to investigations required by the receiving service, where appropriate
- coordinating prerequisite investigations required for referral acceptance
- providing short-term follow-up to confirm successful routing to the receiving service

Moderate-intensity coordination focuses on facilitating access to the appropriate diagnostic pathway rather than providing ongoing navigation. Investigations should not be coordinated if doing so would result in unnecessary delay; patients requiring more comprehensive assessment, diagnostic coordination, or navigation may be escalated to Level 3 support, as appropriate. Responsibility transitions to the receiving service once the referral has been accepted and diagnostic ownership is clearly established.

Level 3 Support: Full SoC Navigation and Diagnostic Coordination

Level 3 support occurs when a referral is accepted into the SoC Service, and the SoC team assumes responsibility forcoordinating the diagnostic process until diagnostic ownership is transferred. At this level, the SoC Service functions as the central coordination point for diagnostic investigations, patient communication, and inter-service collaboration.
Level 3 is typically required when:

- diagnostic complexity requires coordination across multiple investigations or services
- patients face significant barriers affecting diagnostic completion
- the patient lacks a clear Most Responsible Provider
- there is increased risk of diagnostic delay or loss to follow-up
- diagnostic direction remains uncertain and requires coordinated assessment

Activities at this level may include:

- coordinating Tier 2 investigations and diagnostic procedures
- sequencing investigations to support efficient diagnostic progression
- monitoring completion of investigations and tracking results
- maintaining communication with the patient and referring providers
- identifying and addressing barriers to diagnostic completion
- coordinating referral to appropriate specialty or disease-site programs

Navigation continues until diagnostic ownership is formally transferred to another provider or service.

Escalation Triggers

The level of navigation may increase when new information or circumstances indicate that additional coordination is required to maintain patient safety or diagnostic momentum.
Examples of escalation triggers include:

- increasing diagnostic complexity or uncertainty
- emergence of urgent clinical findings
- barriers preventing completion of investigations, including those related to structural inequities or unmet accessibility needs
- risk of patient loss to follow-up
- absence of a clearly accountable provider for ongoing care

Escalation may involve increased navigation intensity, clinician review, or urgent referral to emergency or specialty care where appropriate. Clinical urgency and patient safety supersede pathway timelines or process expectations.

De-Escalation and Exit

Navigation intensity decreases once diagnostic direction becomes clear and responsibility for care transitions to the most appropriate provider or service.

The SoC Service concludes involvement when diagnostic ownership has been clearly accepted by another clinician or service, such as:

- a Diagnostic Assessment Program or disease-site specialist
- another specialty service managing a serious non-cancer diagnosis
- primary care with a clearly documented follow-up plan

Prior to exit, the SoC Service ensures a structured warm handoff, including communication of completed investigations, pending results, recommended next steps, and clarification of ongoing clinical accountability. For patients without a primary care provider, SoC involvement continues until a responsible provider, or service has been identified and a safe follow-up plan is documented. Where a suitable transition provider cannot be identified despite reasonable efforts, the SoC Service will establish a time-limited follow-up plan and support connection to appropriate services (e.g., primary care attachment pathways or community-based care) to ensure patient safety and continuity.

Operational Roles and Processes

The sections below describe how the SoC Service Team operationalizes these expectations in practice, including provider-facing support, referral review, intake and navigation, diagnostic coordination, and transition of care.

1. Provider-Facing Support and Pre-Referral Guidance

The SoC Service provides provider-facing support to referring clinicians seeking guidance on next steps. Provider-facing support is advisory and navigational, and may occur with or without a formal referral, particularly when a referring clinician is uncertain whether a patient's presentation is appropriate for SoC or may be better served through an alternate pathway.

Provider-facing support may be used when:

- symptoms are non-specific, evolving, or borderline for SoC criteria
- there is uncertainty regarding urgency or patient safety
- it is unclear whether Tier 1 investigations are sufficient or appropriate
- the patient is unattached, complex, or at risk of loss to follow-up
- the clinician is attempting to avoid unnecessary ED referral but requires system navigation support

Provider-facing support may include:

- clarification of SoC scope and eligibility
- guidance on urgency and escalation thresholds
- advice on minimum diagnostic work-up or sequencing
- support with pathway selection or redirection
- discussion of navigation considerations for complex or unattached patients

Provider-facing support does **not** include:

- diagnostic assessment or formulation
- interpretation of investigations
- replacement of specialist consultation or ED decision-making
- assumption of ongoing clinical responsibility

2. Referral Review and Vetting

Once a formal referral is received, the SoC Service Team uses the information to:

- Confirm scope and appropriateness, including whether the presentation aligns with a SoC-appropriate symptom cluster or another clinically concerning presentation. Where needed, rationale is clarified during intake to support appropriate routing rather than automatic rejection.
- Validate pathway alignment by reviewing the selected symptom cluster and adjusting routing if the presentation is better suited to an alternate pathway.
- Review Tier 1 investigations (completed, ordered, pending, or missing) against minimum expectations to determine:
    - whether diagnostic work-up can proceed,
    - whether additional investigations are required before or after intake, and
    - whether delay poses a clinical risk.
- Identify navigation and follow-up risks, including unattached status, absence of a Most Responsible Provider (MRP), unstable contact information, significant barriers, or inability to complete investigations locally, to:
    - trigger navigation support,
    - prevent loss to follow-up, and
    - clarify interim clinical accountability.
- Flag referrals requiring clinician review prior to acceptance, redirection, or diagnostic planning due to complexity or uncertainty (e.g., overlapping symptom clusters, competing urgent conditions, unclear diagnostic trajectories).

Key Principles

- Tier 1 investigation incompleteness alone should **not** result in referral rejection. The SoC Service may accept and coordinate diagnostic work-up when delay poses risk or when the referrer cannot complete remaining investigations in a timely manner.
- Unnecessary loopbacks should be avoided, particularly for ED referrals and unattached patients.
- When a clearer or more appropriate pathway exists, referrals should be redirected promptly with clear communication, including the named receiving service and next actionable step.
- Acceptance decisions are grounded in patient safety, pathway appropriateness, feasibility, and risk of delay, not diagnostic certainty alone.

Referrals to Flag for Clinician Review Prior to Acceptance

Flag for clinician review prior to acceptance where risk, uncertainty, or barriers may compromise safe or timely diagnostic progression:

- potential red flags or risk of deterioration (e.g., new neurological deficits, severe or escalating symptoms, unstable vital signs if known)
- high likelihood of urgent specialty involvement (e.g., high-grade, persistent bowel obstruction symptoms, ongoing jaundice)
- diagnostic ambiguity with elevated risk (e.g., complex multimorbidity, conflicting findings, uncertain primary with concerning pattern)
- factors that may compromise the ability to safely or reliably complete diagnostic workup without early clinician oversight, including:
    - inability to attend or complete investigations
    - significant access or geographic barriers
    - safeguarding concerns
    - equity-related factors impacting ability to follow through with recommended care or follow-up

Communication Outcomes

All referral reviews result in one of the following outcomes:

- Accepted - with next steps, anticipated timelines, and outstanding investigations
- Clarification Required - with specific missing information and what would change disposition
- Redirected - with reason, first appropriate service/specialty, and clear next steps

3. Intake, Navigation, and Early Patient Contact (After Acceptance)

Once a referral is accepted, intake and navigation begin immediately. Navigation is an active, ongoing core function of the SoC Service and continues until diagnostic ownership is formally transferred to another provider or service.

Contact Details and Communication Preferences

The SoC Service confirms and documents:

- the best contact phone number and voicemail permission
- permission for email or other electronic communication
- preferred primary language and interpreter or translation needs
- alternate contact information, including:
    - whether the alternate contact is intended for appointment booking only, and
    - identification and clear documentation of any unsafe contact persons (individuals the patient does not wish to be contacted regarding their care)

Accessibility and Safety Needs

The SoC Service assesses and documents:

- mobility needs and falls risk
- hearing, vision, or communication supports
- cognitive or decision-making supports, where relevant

These considerations inform appointment planning, communication approach, and navigation intensity.

Care Continuity Risks

The SoC Service identifies risks related to clinical accountability and follow-up, including:

- whether the patient has a primary care provider
- whether there is an active Most Responsible Referring Provider able to reliably act on results
- gaps requiring provider-facing navigation, shared-care planning, or interim accountability arrangements

Equity, Psychosocial, and Practical Barriers

Assess for barriers that may affect access to care, diagnostic completion, or follow-up:

- transportation challenges or distance from diagnostic services
- difficulty completing investigations locally
- housing instability or financial barriers
- need for culturally safe or community-based navigation
- psychosocial risk indicators, such as distress, anxiety, limited social support, or caregiving burden

Considerations Affecting Investigations and Diagnostic Workup

Identify factors that may affect investigation selection, safety, or coordination:

- medical considerations affecting investigation choice or safety (e.g., contrast allergy, renal impairment)
- imaging constraints (e.g., metal implants or foreign bodies limiting modality options such as MRI)
- need for modification or coordination of investigations (e.g., anticoagulation management, complex comorbidities)
- logistical factors affecting test completion (e.g., need for sedation supports, caregiver accompaniment)

Psychosocial Distress and Anxiety Screening

Where psychosocial distress is suspected based on referral information, patient report, or early navigation contact, the SoC Service may use validated screening tools to support risk identification and appropriate response. Screening tools inform care planning and do not establish a diagnosis. Examples of commonly used validated tools in Ontario include:

- ESAS-r (including the anxiety item)
- GAD-2 or GAD-7; PHQ-2 or PHQ-9

Use of Screening Results

Screening results are used to:

- adjust navigation intensity and frequency of contact
- inform safety-netting and escalation decisions
- trigger targeted referral or support (e.g., psychosocial oncology, social work, primary care supports, or ED where indicated)
- flag the need for clinician review when distress may interfere with safe diagnostic completion or adherence to investigations

Early Patient Orientation to the Suspicion of Cancer Service

Clear early orientation supports informed participation, reduces anxiety, and reinforces safety-netting throughout the diagnostic process. Early orientation ensures that patients understand:

- why they were referred, including symptoms or imaging patterns suspicious for cancer or another serious diagnosis
- what the SoC Service does: coordinates diagnostic testing and routes patients to the first appropriate service or specialty
- what the SoC Service does not do: does not replace ED care, specialty treatment, or long-term surveillance
- what happens next, including expected response-time windows and how the diagnostic process will unfold
- how results will be communicated, and
- who to contact and what to do if symptoms worsen in character or severity

4. Clinical Triage and Tier 1 Review

With clinician oversight where required, the SoC Service Team reviews the clinical context and Tier 1 work-up to confirm eligibility for the SoC Service and determine the most appropriate next diagnostic step.

Activities include:

- targeted clinical history collection, where needed
- review and interpretation of Tier 1 findings (laboratory results, imaging findings [e.g., chest X-ray, ultrasound, mammography, or other first-line imaging], reported symptoms)
- reassessment of clinical risk and pace of assessment as new information becomes available
- documentation of a provisional working diagnostic direction (for routing purposes only; not a definitive diagnosis)
- provision of interim clinical instructions and safety-netting, where required (e.g., what to monitor, when to seek urgent care, who to contact)

At this stage, the SoC Service Team confirms:

- whether the presentation remains appropriate for the SoC Service or is better served through another pathway, and
- whether next steps involve SoC-coordinated Tier 2 investigations or direct routing to a disease-site pathway or specialty.

Common decision scenarios include:

- Tier 1 investigations are incomplete, but delay would pose clinical risk → accept the referral and coordinate outstanding items in parallel
- Tier 1 findings support a clear disease-site pathway → route directly to the appropriate DAP or specialty with a warm handoff
- Findings suggest a serious non-cancer diagnosis → route to the first appropriate service or specialty (e.g., Internal Medicine)
- Information is insufficient to triage safely → request targeted clarification (specific questions or results, not generic requests)

5. Determining Assessment Modality and Need for In-Person Evaluation

Use the least intensive assessment required to support safe and accurate diagnostic progression. Assessment modality and provider should be determined based on clinical need and local operational considerations, including funding and billing structures. Initial assessment may occur through video-based virtual or in-person visit and may be conducted by appropriate members of the care team based on scope of practice. Team-based and delegated models are expected, with nursing, navigation, clerical, and other team members supporting intake, coordination, and triage activities. Physician involvement may include referral review and triage and should be introduced as needed for patients requiring additional medical assessment, decision-making, or diagnostic oversight.

In-person assessment may be required when:

- physical examination is necessary to clarify key findings
- symptoms suggest potential instability or rapid clinical change
- complexity or barriers cannot be safely managed virtually
- safeguarding, cognitive, or communication concerns are present
- planned investigations carry non-trivial risk requiring clinician counselling

Virtual or chart-based assessment may be sufficient when:

- Tier 1 findings already define diagnostic direction
- the patient is clinically stable
- the primary need is navigation, diagnostic coordination, and timely routing rather than physical examination

6. Tier 2 Investigations and Diagnostic Coordination

The SoC Service coordinates Tier 2 investigations in alignment with local workflows and system capacity. Responsibilities include:

- initiating or coordinating Tier 2 orders, where appropriate
- sequencing and clustering investigations to reduce patient burden
- facilitating scheduling and access to investigations, where required
- tracking investigation status (ordered, scheduled, completed) and monitoring for delays following up with diagnostic departments o resolve delays or access issues
- ensuring required prerequisites are complete (e.g., creatinine/eGFR, INR/PTT)
- reviewing results and confirming appropriate follow-up actions
- monitoring for urgent or unexpected findings and triggering escalation when required
- maintaining diagnostic ownership until responsibility is formally transferred

7. Ongoing Navigation During Diagnostic Assessment

While investigations are underway, the SoC Service:

- maintains patient contact proportional to clinical risk and complexity
- reassesses symptoms and psychosocial risk as needed
- identifies new or evolving barriers to diagnostic completion
- coordinates with referring clinicians, MRPs, and specialists to prevent duplication
- prevents loss to follow-up during transitions across diagnostics and services

8. Escalation and Safety Management

If urgent or emergent symptoms or findings arise at any point, the SoC Service Team escalates immediately by:

- directing the patient to the appropriate setting (ED, admission, or urgent specialty care)
- communicating clearly with all involved providers
- maintaining accountability until responsibility is explicitly accepted by the receiving service

9. Diagnostic Synthesis and Decision-Making

Once sufficient information is available, the SoC Service Team:

- synthesizes Tier 1 and Tier 2 findings
- determines whether cancer is confirmed or suspected, a serious non-cancer diagnosis is more likely, or further specialty input is required
- integrates multidisciplinary input where uncertainty persists
- confirms diagnostic direction for routing and transition purposes only (not treatment initiation)

10. Specialist Engagement Principles

To support timely diagnostic progression, the SoC Service engages with regional specialists according to the following principles:

- Where available, centralized referral models should be used to ensure earliest-available specialist assessment.
- Where centralized models do not exist, the SoC Service may maintain an up-to-date specialist directory, including:
    - specialists willing to accept expedited referrals,
    - procedural availability (e.g., endoscopy, cystoscopy, biopsy),
    - known access constraints or temporary closures.
- Referral acknowledgment should occur in accordance with CPSO expectations (within 14 business days). Where feasible, the SoC Service aims to acknowledge referrals within 7 business days to support timely diagnostic progression.
- Not all referrals require urgent assessment. Triage urgency should be clearly defined and documented based on clinical findings (e.g., symptoms, imaging), and communicated with the referral. If the receiving service cannot accommodate the requested timeline, alternative routing may be considered to align with the patient's level of urgency and prevent avoidable delay.
- For referrals requiring urgent or time-sensitive assessment, direct communication between the SoC physician/clinical team and the receiving specialist/service is expected to support timely handoff, escalation, and diagnostic progression. Responsibility for this communication rests with the SoC Service.
- Participation in SoC referrals requires shared understanding that expedited diagnostic progression may include:
    - booking procedures prior to clinic consultation where appropriate,
    - flexibility when some referrals may be cancelled due to evolving staging findings,
    - collaborative communication between SoC navigation and specialist offices.

11. Exit Planning and Transition of Care

The SoC Service does not provide long-term treatment or surveillance. Exit occurs when diagnostic ownership is clearly assumed by another provider or service.
Transition may include:

- acceptance by a Diagnostic Assessment Program (DAP) or specialist
- routing to another appropriate service (e.g., Regional Cancer Programs for malignancy; internal medicine specialty for non-cancer diagnoses)
- transition back to primary care with a clearly defined follow-up plan, including:
    - responsibility for follow-up imaging or investigations, and
    - explicit guidance on when re-referral to the SoC Service or specialty care is indicated

For unattached patients, SoC involvement does not conclude without:

- a clearly identified responsible provider or service, and
- a documented plan for acting on pending results and next steps

12. Communication and Warm Handoff

The Most Responsible Provider (MRP) is accountable for documenting the clinical handoff (e.g., consult note). Where an MRP note is not generated, a concise SoC navigation note in the electronic medical record, copied to relevant providers, is sufficient. This serves as the primary mechanism for communication within the circle of care. Where the original referring clinician or receiving provider is not connected to the shared record, direct communication (e.g., eReferral, fax, secure messaging, or phone, as appropriate) is required to ensure timely receipt of information.

Clinical handoff documentation (MRP consult note or SoC navigation note) should include:

- reason for referral and clinical summary
- key findings and investigations completed and pending
- diagnostic direction or working diagnosis
- clear plan, including next steps and timelines
- clarity on transfer of care and ongoing clinical responsibility
- relevant attachments (e.g., imaging, reports, consult notes), as appropriate

For Emergency Department Referrers (if applicable):

- document relevant information in the shared record to support continuity of care
- maintain internal confirmation that diagnostic coordination has transferred to the SoC Service
  directly notify the ED only if critical findings require urgent re-engagement

Patient-facing communication is provided in Appendix C.

Site-Specific Suspicion of Cancer Symptom Clusters

This section provides disease-site-specific symptom clusters to support pattern recognition and structured diagnostic workup. Each pathway outlines presenting features, minimum Tier 1 and Tier 2 investigations, additional notes, exit criteria, and a reference pathway to support appropriate routing to existing disease-site services. A summary of site-specific features and associated Tier 1 investigations is presented in **Appendix B.**

Breast

Features

- Palpable breast mass
- New-onset breast asymmetry
- Unilateral spontaneous nipple discharge or nipple retraction
- Skin changes (redness, edema) in the absence of infection
- Palpable axillary or neck mass with associated breast symptoms

Tier 1 Investigations (Referring Provider)

- **Imaging:**
  - Bilateral mammogram (digital)
  - Breast/axillary ultrasound, as clinically appropriate

Tier 2 Investigations (SoC Service)

- **Tissue biopsy (as appropriate):**
  - Core biopsy of primary breast lesion (with ER/PR/HER2)
  - Biopsy of suspicious nodal mass (axillary or supraclavicular): FNA or core biopsy (with ER/PR/HER2)
- **Imaging for locally advanced disease:**
  - CT chest/abdomen/pelvis or PET
- **Additional imaging (as recommended by radiology):**
  - Breast MRI
  - Digital breast tomosynthesis
  - Bone scan
  - Contrast-enhanced mammography

Additional Notes

- Locally advanced disease includes:
  - Palpable tumour >5 cm
  - Frank skin or chest wall invasion (fixed to chest wall)
  - Inflammatory breast cancer
  - Fixed or matted enlarged axillary lymph nodes
  - Ipsilateral supraclavicular lymph node enlargement

Exit Criteria

- Non-cancer, imaging-pathology concordant biopsy results
- Clear plan for follow-up imaging (e.g., BI-RADS 3 with repeat imaging in 6 months)
- Pre-malignant (e.g., ductal carcinoma in situ [DCIS]) or malignant biopsy results

Reference Pathway: Ontario Health (Cancer Care Ontario) Breast Cancer Pathway Map

Chest/Lung

Features

- Persistent hemoptysis (unresponsive to treatment or of unknown cause)
- Unresolving pneumonia with imaging concerning for lung cancer
- Suspicious thoracic imaging findings (lung, pleural nodules or mediastinal nodules or masses, pleural effusion, mediastinal or hilar lymphadenopathy)
- Other persistent aerodigestive symptoms (e.g., hoarseness, stridor, superior vena cava [SVC] syndrome)

Tier 1 Investigations (Referring Provider)

- **Imaging:**
  - Chest X-ray or diagnostic chest CT (within 3 months of referral, or updated for new or worsening symptoms)

Tier 2 Investigations (SoC Service)

- **Imaging:**
  - CT of the chest, if not already completed
  - PET-CT, where clinically indicated
  - MRI brain, where clinicically indicated
- **Tissue biopsy (selected based on patient risk and tolerability):**
  - CT-guided transthoracic biopsy
  - Bronchoscopy, including endobronchial ultrasound (EBUS)
  - Pleuroscopy or pleural biopsy
- **Additional investigations (as clinically indicated to support diagnosis, staging and treatment planning)**
  - Pulmonary function testing (PFTs)
  - Cardiac assessment
  - Additional imaging or specialty investigations, as recommended by the receiving service

Additional Notes

- **Immediate referral to the ED is required if any of the following are present:**
  - Suspicion of SVC syndrome (swelling of the neck, face, or arms; increasing shortness of breath; distended neck or chest veins)
  - Large-volume hemoptysis
  - Respiratory distress, low oxygen saturation, or stridor

Exit Criteria

- Non-cancer, imaging pathology concordant biopsy results
- Clear plan for repeat imaging (e.g., CT of the chest repeated in 3-6 months)
- Malignant biopsy results

Reference Pathway: Ontario Health (Cancer Care Ontario) Lung Cancer Pathway Map

Genitourinary

Features

- **Testes:** Testicular mass, with or without retroperitoneal or mediastinal lymphadenopathy
- **Prostate:** Abnormal digital rectal examination suggesting mass or nodule; elevated PSA; urinary retention; pelvic pain; hematospermia; bone pain
- **Bladder:** Hematuria (gross or microscopic), lower abdominal or pelvic pain, hydronephrosis
- **Kidney**: Renal mass (incidental or symptomatic), flank pain, hematuria, hydronephrosis
- **Penis:** Penile mass, with or without bleeding, pain, or inguinal lymphadenopathy.

Tier 1 Investigations (Referring Provider)

- **Physical examination:**
  - External genital examination (including testes and inguinal lymph nodes)
  - Digital rectal examination
  - If examination is not feasible, an appropriate imaging alternative may be used
- **Imaging (presentation-specific):**
  - **Testicular suspected**: Testicular ultrasound (± inguinal nodal basin, if indicated)
  - **Bladder suspected:** Pelvic ultrasound (first line for suspected bladder mass or hydronephrosis)
  - **Renal suspected:** Renal ultrasound or CT KUB (for suspected renal mass, hematuria, or hydronephrosis)
  - **Prostate suspected:** Prostate ultrasound: Not recommended for isolated elevated PSA; should be ordered only if hydronephrosis or urinary obstruction is demonstrated on imaging

Tier 2 Investigations (SoC Service)

- **Testes:**
  - Blood work: Alpha-fetoprotein (AFP), beta-human chorionic gonadotropin (β-hCG), lactate dehydrogenase (LDH)
  - Imaging: CT of the chest, abdomen, and pelvis (CT CAP)
- **Prostate:**
  - Blood work: Prostate-specific antigen (PSA)
  - Tissue biopsy: Prostate biopsy, as appropriate
  - Imaging (in consultation with a specialist): CT CAP, bone scan, prostate MRI
- **Bladder:**
  - Tissue biopsy (in consultation with a specialist): Cystoscopy with tissue biopsy or TURBT; urinary cytology
  - Imaging (in consultation with a specialist): CT CAP; MRI, as appropriate
- **Kidney:**
  - Imaging: CT CAP; MRI (in consultation with a specialist)
  - Tissue biopsy (in consultation with a specialist)
- **Penis:**
  - Tissue biopsy: Image-guided nodal biopsy, as appropriate; tissue biopsy of the skin lesion (in consultation with a specialist)
  - Imaging (in consultation with a specialist): CT CAP
- **Sarcoma consideration (retroperitoneal, abdominal, or pelvic lesion) in consultation or directed by a sarcoma specialist:**
  - Imaging: MRI
  - Tissue biopsy

Additional Notes

- Avoid duplication of imaging where recent, adequate studies already exist

Exit Criteria

- Non-cancer, imaging-pathology concordant biopsy results
- Clear plan for repeat imaging (e.g., repeat pelvic ultrasound in 6 months)
- Pre-malignant or malignant biopsy results

Reference Pathways:

Ontario Health (Cancer Care Ontario Bladder Cancer Pathway Map
Ontario Health (Cancer Care Ontario) Prostate Cancer Pathway Map

Features

- **Ovarian:** Ovarian mass; ascites with peritoneal thickening; omental caking
- **Endometrial:** Abnormal vaginal bleeding[1] (including post-menopausal bleeding); lower back or pelvic pain; ascites; omental caking or peritoneal disease; profuse vaginal discharge
- **Cervical:** Contact bleeding (including post-coital); cervical mass; sciatic or lower back pain; copious vaginal discharge; new-onset pelvic pain; unilateral leg swelling in the absence of DVT
- **Vaginal/Vulvar:** Bleeding or painful mass; persistent ulcer; enlarged inguinal lymph nodes

Tier 1 Investigations (Referring Provider)

- **All patients:**
  - Physical examination: abdominal and pelvic examination, if not already completed
  - Urinalysis
- **If anemia or bleeding suspected:**
  - Blood work: complete blood count (CBC); iron studies
- **Imaging (as appropriate):**
  - **Ovarian and endometrial suspected:** pelvic ultrasound (first line; ± transvaginal ultrasound at radiology discretion; include O-RADS classification for ovarian masses); Pelvic ultrasound is generally not recommended for isolated cervical or vaginal presentations

Tier 2 Investigations (SoC Service)

- **Ovarian:**
  - Blood work: CA-125 and/or germ cell tumour markers (see Appendix C)[2]
  - Isolated ovarian mass: pelvic MRI (in consultation with gynecologic oncology; OTN eConsult as appropriate)
  - Disseminated or metastatic disease (e.g., ascites, omental caking, O-RADS 5 masses):
    - Tissue biopsy or procedure: ascites tap for cytology; image-guided biopsy of omental mass
    - Imaging: CT of the chest, abdomen, and pelvis (CT CAP)
- **Endometrial:**
  - Tissue biopsy: endometrial biopsy (pipelle biopsy)
  - Imaging: CT CAP, where appropriate
- **Cervical:**
  - Tissue biopsy: cervical biopsy or referral to colposcopy/gynecology for biopsy
  - Imaging: CT CAP, where appropriate
  - Include relevant prior cervical screening results, where available

Vaginal/Vulvar:

- Tissue biopsy: referral to colposcopy/gynecology for biopsy
- Ultrasound-guided inguinal nodal biopsy, as appropriate

Additional Notes

- [1] Abnormal vaginal bleeding includes bleeding outside regular menses; heavier or prolonged menses; bleeding between menses or after intercourse
- [2] CA-125 is appropriate in post-menopausal patients with an ovarian mass; it is less reliable and not recommended in pre-menopausal patients
- In patients with a visible or symptomatic cervical lesion, HPV/Pap testing should not delay referral or tissue diagnosis due to the risk of false-negative results.
- O-RADS classification should be reviewed, where available, to support risk stratification and referral planning. Particular attention should be given to O-RADS 5 masses and selected O-RADS 4 masses.
- Consider eConsult with Provincial Gynecologic Oncology eConsult Service  or the Provincial Gynecologic Pelvic Mass eConsult Service 

  Access Note: A Valid One ID account is required to access these resources. Providers who do not have a one ID account can register through the CPSO website.

Exit Criteria

- Non-cancer, imaging-–pathology concordant biopsy results
- Clear plan for repeat imaging (e.g., repeat pelvic ultrasound in 6 months)
- Pre-malignant or malignant biopsy results

Reference Pathways:

Ontario Health (Cancer Care Ontario Ovarian Cancer Pathway Map
Ontario Health (Cancer Care Ontario) Endometrial Cancer Pathway Map
Ontario Health (Cancer Care Ontario) Cervical Cancer Pathway Map
Ontario Health (Cancer Care Ontario) Toolkit for Ontario Colposcopists

Head and Neck

Features

- Neck mass or cervical lymphadenopathy (visible or palpable), including parotid masses
- Persistent oral or oropharyngeal lesion (e.g., non-healing ulceration or unexplained mucosal bleeding)
- Cranial nerve abnormality
- Persistent upper aerodigestive symptoms: dysphagia, odynophagia, dysphonia, otalgia, or throat pain with non-malignant causes ruled out
- Systemic symptoms: unexplained weight loss, fever, night sweats
- Thyroid nodule or mass with concerning features (e.g., rapid growth, compressive symptoms, or suspicious imaging findings)

Tier 1 Investigations (Referring Provider)

- **Imaging:**
  - Ultrasound of neck for suspected mass (including parotid glands when clinically indicated)
  - Chest X-ray

Tier 2 Investigations (SoC Service)

- **Imaging:**
  - CT of the neck and chest (abdomen and pelvis as required or clinically indicated)
- **Tissue biopsy:**
  - Fine-needle aspiration (FNA) or core biopsy of the neck mass
- **Specialist-directed investigations (in consultation with an ENT or Head & Neck specialist):**
  - Endoscopic examination and/or biopsy: laryngoscopy or esophagogastroduodenoscopy (EGD)
  - Imaging: MRI, as appropriate
  - Blood work (if lymphoma suspected): complete blood count (CBC); lactate dehydrogenase (LDH)

Additional Notes

- Concern for airway compromise or severe dysphagia should prompt immediate referral to the ED
- In patients with cutaneous malignancies of the face and/or scalp, particular attention should be paid to the parotid region; parotid masses in this context may represent metastatic disease and should not be presumed benign

Exit Criteria

- Non-cancer, imaging-pathology concordant biopsy results
- Clear plan for repeat imaging (e.g., repeat thyroid ultrasound in 6 months)
- Pre-malignant or malignant biopsy results

Reference Pathway:

Ontario Health (Cancer Care Ontario) Oropharyngeal Cancer Pathway Map
Ontario Health (Cancer Care Ontario) Cervical Lymphadenopathy Pathway Map
Ontario Health (Cancer Care Ontario) Thyroid Cancer Pathway Map
Ontario Health (Cancer Care Ontario) Cervical Lymphadenopathy in Adults Pathway Map

Hepatopancreaticobiliary

Features

- Jaundice, clinical or biochemical (total bilirubin >80 µmol/L), with associated pruritus, dark urine, or light-coloured stools
- Ascites
- Persistent upper abdominal pain or central back pain
- Unintentional, unexplained weight loss
- Symptoms of gastric outlet obstruction (anorexia, early satiety, nausea, vomiting)

Tier 1 Investigations (Referring Provider)

- **Blood work:**
  - Complete Blood Count (CBC)
  - Liver function tests (ALT, ALP, total bilirubin, glucose, albumin, INR)
  - Renal function panel (serum creatinine, eGFR, sodium, potassium, chloride)
- **Imaging:**
  - Abdominal ultrasound

Tier 2 Investigations (SoC Service)

- **Blood work:**
  - Where clinically appropriate, selective use of adjunct tumour markers may support diagnostic direction (see Appendix C).
- **Imaging:**
  - CT of the chest, abdomen, and pelvis (CT CAP)
    - If pancreatic cancer is suspected: pancreas-protocol CT
  - Additional imaging (in consultation with HPB or imaging specialist):
    - MRI of the liver or magnetic resonance cholangiopancreatography (MRCP)
    - Gallium-68 DOTATATE PET or PET/CT
- **Biopsy / procedures (in consultation with a specialist):**
  - Endoscopic retrograde cholangiopancreatography (ERCP)
  - Esophagogastroduodenoscopy (EGD)/Endoscopic ultrasound (EUS) for pancreatic/other HPB lesions
  - Image-guided biopsy of primary lesion or metastatic focus (e.g., omental metastases)

Additional Notes

- Concern for upper gastrointestinal bleeding or cholangitis/sepsis should prompt immediate referral to the ED
- Reference pathways:
  - Ontario Health (Cancer Care Ontario) Hepatocellular Cancer Pathway Map
  - Ontario Health (Cancer Care Ontario) Hepatic, Pancreatic and Biliary Tract Surgical Oncology Standards

Exit Criteria

- Non-cancer, imaging-pathology concordant biopsy results
- Clear plan for repeat imaging (e.g., CT in 6 months)
- Pre-malignant or malignant biopsy results

Reference pathways:

Ontario Health (Cancer Care Ontario Hepatocellular Cancer Pathway Map;
Ontario Health (Cancer Care Ontario) Hepatic, Pancreatic and Biliary Tract Surgical Oncology Standards

Luminal Gastrointestinal (Upper and Lower GI)

Features

Upper GI (esophagus, stomach, duodenum)

- New or worsening dysphagia, dyspepsia, or odynophagia
- Signs of upper gastrointestinal bleeding (hematemesis, melena, or iron-deficiency anemia)
- Symptoms of gastric outlet obstruction (early satiety; new or worsening upper abdominal pain; anorexia with reduced intake; nausea; vomiting)
- Abdominal distention
- Unintentional, unexplained weight loss or malnutrition

Lower GI (small intestine, colon, rectum, anal)

- Signs of lower gastrointestinal bleeding (rectal bleeding, melena, or iron-deficiency anemia)
- Change in bowel habits (new or worsening constipation or diarrhea)
- Abdominal distention
- Palpable mass or perianal symptoms (abdominal mass, or rectal mass with associated pain/pruritis)
- Unintentional, unexplained weight loss

Tier 1 Investigations (Referring Provider)

- **Blood work:**
  - Complete Blood Count (CBC)
  - Liver function tests (ALT, ALP, total bilirubin, glucose, albumin, INR)
  - Renal function panel (serum creatinine, eGFR, sodium, potassium, chloride)
  - Iron Studies
- **Physical examination:**
  - Digital rectal examination
  - Inguinal lymph node examination, as appropriate

Tier 2 Investigations (SoC Service)

- **Blood work:**
  - Where clinically appropriate, selective use of adjunct tumour markers may support diagnostic direction (see Appendix).
- **Tissue biopsy / endoscopy:**
  - Tissue biopsy, as appropriate
  - In consultation with a specialist:
    - Esophagogastroduodenoscopy (EGD) with biopsy
    - Colonoscopy with biopsy
  - If nodal or distant metastatic disease is identified on imaging, consider image-guided biopsy of:
    - A lymph node (e.g., inguinal lymph node in anal cancer), or
    - A metastatic deposit (e.g., omental cake)
  - If sarcoma is suspected (retroperitoneal, abdominal, or pelvic lesion):
    - In consultation with sarcoma specialist:
      - Additional imaging with MRI
      - Tissue biopsy (e.g., image-guided core biopsy)
- **Imaging:**
  - CT of the chest, abdomen, and pelvis (CT CAP)
  - In consultation with a specialist (surgical or imaging):
    - Pelvic MRI for rectal cancer
    - Abdominal MRI for retroperitoneal lesions
    - PET/CT for esophageal or anal cancer
    - Gallium-68 DOTATATE PET for suspected neuroendocrine tumours

Additional Notes

- Concern for clinically significant gastrointestinal blood loss (including hemodynamic instability, large-volume bleeding, severe anemia [hemoglobin <80 g/L], hypovolemia, or gastrointestinal obstruction) should prompt urgent referral to the ED

Exit Criteria

- Non-cancer, imaging-pathology concordant biopsy results
- Clear plan for repeat imaging (e.g., repeat CT in 6 months)
- Pre-malignant or malignant biopsy results

REFERENCE PATHWAY:

Ontario Health (Cancer Care Ontario Esophageal Cancer Pathway Map
Ontario Health (Cancer Care Ontario) Colorectal Cancer Pathway Map

Skin/Soft Tissue

Features

Cutaneous / skin / mucosal / nail bed (one or more)

- Suspicious pigmented or amelanotic skin lesion with concerning ABCDE features[1], bleeding, or ulceration
- Evidence of cutaneous or subcutaneous satellite lesions (pigmented lesions in the vicinity of the primary lesion)
- Palpable lymphadenopathy associated with a skin lesion (draining lymphatic basin)

Soft tissue

- Palpable soft-tissue mass (extremity, trunk, head and neck) that is >5 cm, or any size with one or more of the following:
    - Rapid growth
    - Pain
    - Recurrence after removal
    - Fixation to deep structures (bone, fascia, joint)
    - 3-5 cm mass directly over bone or in popliteal, groin, antecubital, or axillary regions

Tier 1 Investigations (Referring Provider)

Cutaneous

- Tissue biopsy: punch biopsy or excisional biopsy of the primary skin lesion
- Imaging: ultrasound of the affected nodal basin if palpable lymphadenopathy is present

Soft tissue

- Imaging: ultrasound of the area of concern
- X-ray (plain radiograph) if the mass is fixed to bone or joint

Tier 2 Investigations (SoC Service)

Cutaneous (once melanoma or other high-risk cutaneous malignancy is identified)

- Imaging for locally advanced disease (e.g., satellite lesions or palpable lymphadenopathy):
    - CT of the chest, abdomen, and pelvis (CT CAP) or PET/CT (preferred)
- Tissue biopsy:
    - Core biopsy or fine-needle aspiration (FNA) of nodal disease

Soft tissue

- Specialist consultation: consultation with a sarcoma specialist if initial imaging is concerning
- Additional imaging (as required): CT or MRI
- Tissue biopsy: image-guided core biopsy or excisional/incisional biopsy

Additional Notes

- Can be used as the default pathway for soft tissue masses that do not clearly align with another disease-site-specific pathway.
- [1] **ABCDE features of high-risk pigmented skin lesions:**
    - **Asymmetry:** one half does not match the other
    - **Border:** irregular, scalloped, or poorly defined
    - **Colour:** variation within the same lesion
    - **Dimension:** >6 mm in diameter
    - **Evolution:** documented change in size, shape, or colour over time
- Palpable lymphadenopathy should be assessed in the drainage basin of the primary skin lesion
- Reference pathways:
    - Ontario Health (Cancer Care Ontario) Soft Tissue Sarcoma Pathway Map
    - Ontario Health (Cancer Care Ontario) Skin Cancer Pathway Map

Exit Criteria

- Non-cancer biopsy results
- Clear plan for repeat imaging (e.g., repeat MRI in 1 year)
- Malignant biopsy or confirmation of cutaneous malignancy or sarcoma with transition to disease-site-specific management and/or additional specialist-directed workup

Reference Pathway:

Ontario Health (Cancer Care Ontario) Soft Tissue Sarcoma Pathway Map
Ontario Health (Cancer Care Ontario) Skin Cancer Pathway Map

Non-Site-Specific Suspicion of Cancer Symptom Clusters

This section defines the SoC symptom clusters that commonly fall outside traditional disease-site pathway thresholds, including **hematologic, constitutional,** and **imaging-led presentations**. It is intended to support consistent triage for patients with non-specific or ambiguous presentations where diagnostic coordination and pathway ownership may be unclear. The symptom clusters are illustrative and not exhaustive, and do not replace clinical judgment; clinicians should apply professional judgment and escalate care whenever symptoms, findings, or patient status raise concern for clinical deterioration or immediate risk.

Hematologic Symptom Clusters

This section outlines hematologic presentations and minimum investigations to support timely identification of hematologic malignancies and appropriate routing to hematology pathways. It emphasizes safety, appropriate use of imaging, and specialist consultation when indicated.

Leukemia/Cytopenia-Cytosis Pattern

Features

- Anemia
- Cytopenias (e.g., leukopenia, thrombocytopenia, pancytopenia)
- Cytoses (e.g., leukocytosis, thrombocytosis, erythrocytosis)
- B symptoms (fever, night sweats, weight loss)

Tier 1 Investigations (Referring Provider)

- **Blood work:**
  - Complete Blood Count (CBC)
  - Renal function panel (serum creatinine, eGFR, sodium, potassium, chloride)
  - Liver function tests (ALT, ALP, total bilirubin, glucose, albumin, INR)
  - C-reactive protein (CRP)
  - Lactate dehydrogenase (LDH)
- **Urine:**
  - Urinalysis (routine and microscopy)
- **Imaging:**
  - Chest X-ray if cardiopulmonary symptoms are present or physical examination is abnormal

Tier 2 Investigations (SoC Service)

- **Initial hematologic investigations** (low burden / readily available):
  - Peripheral blood smear review if not already completed with the CBC
  - Reticulocyte count
- **If lymphoma is suspected based on Tier 1 findings:**
  - CT of the chest, abdomen, and pelvis (CT CAP)
  - Image-guided tissue biopsy
- **In consultation with a specialist** (hematologist or hematologist-oncologist):
  - Flow cytometry (on peripheral blood)
- **If plasma cell disorder or myeloma is suspected:**
  - Serum protein electrophoresis (SPEP)
  - Serum free light chains (FLC)

Additional Notes

- Avoid imaging for isolated cytopenias or cytoses unless clinically indicated
- Urgent referral to hematology or the ED is required if acute leukemia, hyperleukocytosis, or severe cytopenias are suspected

Exit Criteria

- Tissue diagnosis confirming a hematologic malignancy (e.g., bone marrow or tissue biopsy)
- Entry into a disease-site-specific hematologic diagnostic pathway
- Alternative non-cancer etiology identified with a management plan established
- No evidence of malignancy, with a clear follow-up plan communicated

Lymphoma Pattern

Features

- Lymphadenopathy
- Splenomegaly
- B symptoms (fever, night sweats, weight loss)
- Cytopenias or cytoses on blood work

Tier 1 Investigations (Referring Provider)

- **Blood work:**
  - Complete Blood Count (CBC)
  - Renal function panel (serum creatinine, eGFR, sodium, potassium, chloride)
  - Liver function tests (ALT, ALP, total bilirubin, glucose, albumin, INR)
  - C-reactive protein (CRP)
  - Lactate dehydrogenase (LDH)
- **Urine:**
  - Urinalysis (routine and microscopy)
- **Imaging:**
  - Ultrasound of lymph nodes and/or spleen, based on physical examination findings
  - Chest X-ray if cardiopulmonary symptoms are present or physical examination is abnormal

Tier 2 Investigations (SoC Service)

- **Laboratory investigations:**
  - Uric acid
- **Imaging:**
  - CT of the chest, abdomen, and pelvis (CT CAP) for abnormal ultrasound findings or enlarging lymph nodes (unless contraindicated)
  - CT of the neck if cervical lymph nodes are abnormal on ultrasound or are clinically progressive
- **Tissue diagnosis:**
  - Image-guided biopsy of suspicious lymph nodes, or specialist-directed biopsy for non-nodal disease
  - *Note: flow cytometry will be performed on biopsy specimens, as appropriate*
- **In consultation with a specialist** (hematologist or hematologist-oncologist), as appropriate:
  - Peripheral blood smear review
  - Peripheral blood flow cytometry, if indicated
  - PET/CT, where clinically indicated for staging or further characterization
  - Cardiac assessment (e.g., echocardiogram or MUGA scan), as directed for treatment planning

Additional Notes

- Selection of biopsy site and modality should prioritize diagnostic yield and patient safety
- Avoid unnecessary duplication of imaging where recent, adequate studies already exist

Exit Criteria

- Tissue diagnosis confirming a hematologic malignancy (e.g., lymph node or bone marrow biopsy)
- Entry into a disease-site-specific hematologic diagnostic pathway
- Alternative non-cancer etiology identified with a management plan established
- No evidence of malignancy, with a clear follow-up plan communicated

MPN/Myeloma Pattern

Features

- Splenomegaly
- Bone pain or lytic bone lesions without a clear non-cancer cause
- Cytopenias (e.g., anemia, thrombocytopenia)
- Cytoses (e.g., thrombocytosis, erythrocytosis, eosinophilia)
- Mild hypercalcemia
- Chronic or worsening renal dysfunction

Tier 1 Investigations (Referring Provider)

- **Blood work:**
  - Complete Blood Count (CBC)
  - Renal function panel (serum creatinine, eGFR, sodium, potassium, chloride)
  - Liver function tests (ALT, ALP, total bilirubin, glucose, albumin, INR)
  - C-reactive protein (CRP)
  - Lactate dehydrogenase (LDH)
  - Bone profile (calcium)
- **Urine:**
  - Urinalysis (routine and microscopy)
- **Imaging:**
  - Ultrasound of lymph nodes and/or spleen, based on physical examination findings
  - Targeted X-ray for focal bone pain
  - Chest X-ray if cardiopulmonary symptoms are present or physical examination is abnormal

Tier 2 Investigations (SoC Service)

- **Initial hematologic investigations (low burden / readily available):**
  - Peripheral blood smear review, if not already completed with the CBC
  - Serum erythropoietin (EPO) level, where CBC demonstrates erythrocytosis
- **If a plasma cell disorder or multiple myeloma is suspected:**
  - Serum protein electrophoresis (SPEP)
  - Serum free light chains (FLC)
  - Immunofixation electrophoresis (IFE), where screening investigations are abnormal or suspicion remains high
  - Quantitative immunoglobulins, where clinically indicated
- **If myeloma is suspected, in collaboration with or following referral to a hematologist or hematologist-oncologist:**
  - Low-dose computed tomography (LDCT) skeletal survey (preferred where available), or X-ray skeletal survey if LDCT is unavailable
- **If a myeloproliferative neoplasm (MPN) is suspected:**
  - **Peripheral blood molecular testing, as appropriate:**
    - **JAK2 mutation analysis**
    - **CALR mutation analysis**
    - **MPL mutation analysis**
- **In collaboration with or following referral to a hematologist or hematologist-oncologist, where clinically indicated:**
  - Bone marrow aspirate and biopsy
  - Molecular and genomic testing, as appropriate

Additional Notes

- Tier 1 and Tier 2 investigations may proceed concurrently when severe abnormalities are present
- Imaging should be targeted and clinically justified to avoid unnecessary testing

Exit Criteria

- Tissue diagnosis confirming a hematologic malignancy (e.g., bone marrow biopsy)
- Entry into a disease-site-specific hematologic diagnostic pathway
- Alternative non-cancer etiology identified with a management plan established
- No evidence of malignancy, with a clear follow-up plan communicated

Constitutional Symptom Clusters

This section addresses non-site-specific presentations that may represent malignancy or other serious diagnoses. It provides minimum investigations and routing principles while reinforcing safety-netting and escalation when red flags emerge. Where feasible, Tier 1 investigations should be completed prior to referral. Referral to the SOC Service is supported when Tier 1 results demonstrate abnormalities consistent with possible malignancy, or when clinical concern persists and Tier 2 investigations are required to further evaluate the presentation.

Weight Loss

Features

- Unintentional, unexplained ≥10% body weight loss

Tier 1 Investigations (Referring Provider)

- **Blood work:**
  - Complete Blood Count (CBC)
  - Renal function panel (serum creatinine, eGFR, sodium, potassium, chloride)
  - Liver function tests (ALT, ALP, total bilirubin, glucose, albumin, INR)
  - C-reactive protein (CRP)
  - Thyroid-stimulating hormone (TSH)
- **Urine:**
  - Urinalysis (routine and microscopy)
- **Imaging:**
  - Chest X-ray if cardiopulmonary symptoms are present or physical examination is abnormal

Tier 2 Investigations (SoC Service)

- CT of the chest, abdomen, and pelvis (CT CAP) if weight loss is rapid, severe, or progressive, or if Tier 1 findings raise concern; may be ordered earlier based on clinical judgment
- Endoscopic evaluation (esophagogastroduodenoscopy and/or colonoscopy), **initiated as indicated by imaging findings**

Additional Notes

- Consider and exclude common non-malignant causes (e.g., hyperthyroidism, diabetes, medication effects, diet or exercise changes)
- Consider brief depression or anxiety screening, where clinically appropriate
- Attach available organized cancer screening results from the past 1-3 years (new screening is not required)

Exit Criteria

- Tissue diagnosis confirming malignancy
- Entry into a disease-site-specific diagnostic pathway
- Alternate non-cancer etiology identified with a management plan
- No evidence of malignancy, with a clear follow-up plan communicated

Fatigue

Features

- Persistent, unexplained fatigue not relieved by rest and functionally impairing

Tier 1 Investigations (Referring Provider)

- **Blood work:**
  - Complete Blood Count (CBC)
  - Renal function panel (serum creatinine, eGFR, sodium, potassium, chloride)
  - Liver function tests (ALT, ALP, total bilirubin, glucose, albumin, INR)
  - C-reactive protein (CRP)
  - Thyroid-stimulating hormone (TSH)
- **Urine:**
  - Urinalysis (routine and microscopy)
- **Imaging:**
  - Chest X-ray **only if** cardiopulmonary symptoms are present

Tier 2 Investigations (SoC Service)

- If myeloma red flags are present (bone pain, anemia, renal impairment):
  - Serum protein electrophoresis (SPEP)
  - Serum free light chains (FLC)
  - Serum calcium
- CT CAP **only if** systemic symptoms, significant Tier 1 abnormalities, or high clinical suspicion are present

Exit Criteria

- Tissue diagnosis confirming malignancy
- Entry into a disease-site-specific diagnostic pathway
- Alternate non-cancer etiology identified with a management plan
- No evidence of malignancy, with a clear follow-up plan communicated

Bone Pain (Long Bone and Spine)

Features

- Pain with weight-bearing
- Suspected pathologic fracture
- Motor or sensory deficit
- Back pain with neurologic features
- New bowel or bladder dysfunction

Tier 1 Investigations (Referring Provider)

- **Blood work:**
  - Complete Blood Count (CBC)
  - Renal function panel (serum creatinine, eGFR, sodium, potassium, chloride)
  - Liver function tests (ALT, AST, ALP, total bilirubin, glucose, albumin, INR)
  - C-reactive protein (CRP)
- Bone profile (calcium)
- **Urine:**
  - Urinalysis (routine and microscopy)
- **Imaging:**
  - Targeted X-ray of the symptomatic area

Tier 2 Investigations (SoC Service)

- **Suspected primary bone or spine lesion:**
  - CT of the symptomatic area
  - MRI **only in consultation** with spine surgery, orthopedic surgery, or orthopedic oncology
- **Only following consultation with a hematologist and when myeloma is suspected:**
  - Low-dose CT (LDCT) skeletal survey (preferred), or
  - X-ray skeletal survey if LDCT unavailable
- **If myeloma red flags are present:**
  - SPEP
  - Serum free light chains (FLC)

Additional Notes

- ED referral is required for spinal cord compression or pathologic fracture with neurologic compromise
- MRI is reserved for spinal red flags (neurologic deficit, bowel/bladder dysfunction, progressive weakness, night pain)
- Typical mechanical or osteoporotic pain should be managed outside SoC pathways

Exit Criteria

- Tissue diagnosis confirming malignancy
- Entry into a disease-site-specific diagnostic pathway
- Alternate non-cancer etiology identified with a management plan
- No evidence of malignancy, with a clear follow-up plan communicated

Abdominal or Pelvic Pain

Features

- Persistent abdominal pain with no identified etiology
- Persistent pelvic pain with no identified etiology

Tier 1 Investigations (Referring Provider)

- **Blood work:**
  - Complete Blood Count (CBC)
  - Renal function panel (serum creatinine, eGFR, sodium, potassium, chloride)
  - Liver function tests (ALT, ALP, total bilirubin, glucose, albumin, INR)
  - C-reactive protein (CRP)
- **Urine:**
  - Urinalysis (routine and microscopy)
- **Imaging:**
  - Ultrasound of the abdomen or pelvis

Tier 2 Investigations (SoC Service)

- CT CAP with contrast if ultrasound findings are abnormal, **or** if ultrasound is normal but symptoms are severe or persistent

Additional Notes

- Pelvic ultrasound protocol (transabdominal ± transvaginal) as determined by radiology
- Follow radiologist recommendations for further characterization
- Initiate endoscopic evaluation **only as indicated by imaging findings**

Exit Criteria

- Tissue diagnosis confirming malignancy
- Entry into a disease-site-specific diagnostic pathway
- Alternate non-cancer etiology identified with a management plan
- No evidence of malignancy, with a clear follow-up plan communicated

Neurologic Pattern

Features

- New or different headaches
- Persistent headaches not resolving with usual therapy
- Headaches with focal neurologic symptoms (e.g., gait change, personality or behavioural change)
- Headache without an emerging diagnostic pattern after 2 or more weeks
- Symptoms suggestive of paraneoplastic neurologic syndromes, particularly in patients with a current or prior history of cancer (e.g., encephalopathy, behavioural or cognitive change, ataxia, or multifocal neurologic deficits without another clear cause)

Tier 1 Investigations (Referring Provider)

- **Blood work:**
  - Complete Blood Count (CBC)
  - Renal function panel (serum creatinine, eGFR, sodium, potassium, chloride)
  - Liver function tests (ALT, ALP, total bilirubin, glucose, albumin, INR)
  - C-reactive protein (CRP)
- **Urine:**
  - Urinalysis (routine and microscopy)
- **Imaging:**
  - Non-contrast CT head

Tier 2 Investigations (SoC Service)

- **Brain MRI** is indicated if:
  - CT head is abnormal or inconclusive, or
  - Neurologic symptoms persist or progress despite a non-diagnostic CT
- **If CT head findings are consistent with brain metastases:**
  - Urgent brain MRI (target within 72 hours)
  - If no known primary malignancy:
    - CT of the chest, abdomen, and pelvis (CT CAP)
    - Where clinically appropriate, selective use of adjunct tumour markers (see Appendix C).
    - Tissue biopsy (preferably from a non-central nervous system site; may require endoscopic or image-guided approaches)

Additional Notes

- **Imaging urgency guidance[2]:**
  - *Red-flag presentations (seizure, sudden-onset severe headache, acute focal neurologic deficit) require immediate referral to the ED*
  - *Orange-flag presentations* (new focal neurologic deficits, rapidly progressive symptoms, , headaches with concerning neurologic features): CT head within 48 hours
  - *Yellow-flag presentations* (persistent or unexplained headaches without focal deficits or systemic red flags): CT head within 2 weeks
- Primary care providers should order CT head directly prior to SoC Service referral where appropriate
- Some patients may require ED-based CT if timely outpatient imaging (within 48 hours) is not feasible
- New neurologic symptoms in patients with a remote history of cancers with late-recurrence risk may warrant urgent imaging even if symptoms are subtle
- Apply clinical judgment for chronic or clearly non-malignant symptom patterns

Exit Criteria

- Tissue diagnosis confirming malignancy (often from a non-central nervous system site, where applicable)
- Entry into a disease-site-specific diagnostic pathway (e.g., neuro-oncology or primary site pathway)
- Alternate non-cancer etiology identified with a management plan established
- No evidence of malignancy, with a clear follow-up plan communicated to the referring provider

[2] **Kernick D, Stapley S, Hamilton W.** "Imaging patients with suspected brain tumour: guidance for primary care." *Br J Gen Pract*. 2008 Dec;58(557):880-5. doi: 10.3399/bjgp08X376203.

Imaging-Led Suspicion of Cancer

This section supports referrals triggered by suspicious, indeterminate, or incidental imaging findings without clear pathway ownership. It provides guidance on imaging clarification, appropriate use of tumour markers (only when imaging suggests an organ-specific primary), tissue diagnosis strategies, and clear exit criteria to ensure safe transitions of care.

Abnormal or Significant Incidental Imaging Findings

Features

- Suspicious imaging finding concerning for malignancy
- Incidental imaging finding reported as indeterminate or suspicious with no documented follow-up plan
- Metastatic-pattern (diffuse or multifocal) imaging findings without a clear primary tumour

Tier 1 Investigations (Referring Provider)

- **Blood work:**
  - Complete Blood Count (CBC)
  - Renal function panel (serum creatinine, eGFR, sodium, potassium, chloride)
  - Liver function tests (ALT, ALP, total bilirubin, glucose, albumin, INR)
  - C-reactive protein (CRP)
  - Thyroid-stimulating hormone (TSH)
  - Where clinically appropriate, selective use of adjunct tumour markers (see Appendix C).
- **Urine:**
  - Urinalysis (routine and microscopy)

Tier 2 Investigations (SoC Service)

- **Additional imaging:**
  - Contrast-enhanced CT of the chest, abdomen, and pelvis (CT CAP) **only if** initial imaging was non-contrast, incomplete, or indeterminate
  - Organ-specific imaging, as directed by radiology based on suspected organ of origin, including:
    - Liver MRI
    - Pancreas-protocol CT or MRI
    - Adrenal or renal protocol CT
    - Dedicated chest CT
- **Tissue diagnosis:**
  - Image-guided biopsy of a suspicious mass or lymph node when tissue diagnosis is required
  - When a gastrointestinal primary is suspected and no other tissue is safely accessible:
    - Endoscopic evaluation (esophagogastroduodenoscopy or colonoscopy) **only if** imaging demonstrates a gastrointestinal tract abnormality

Additional Notes

- Do **not** repeat CT CAP if a recent, adequate contrast-enhanced study is already available
- Where clinically appropriate and radiologically indicated (i.e., when imaging suggests a specific organ of origin), selective use of adjunct tumour markers may be considered (see Appendix C)

Exit Criteria

- Tissue diagnosis confirming malignancy
- Entry into a disease-site-specific diagnostic pathway
- Alternative benign etiology identified, with an appropriate management plan established
- No evidence of malignancy following appropriate imaging clarification, with a clear follow-up plan communicated to the referring provider

Case Scenarios

The following clinical scenarios are provided to support consistent interpretation and application of the SoC clinical guidance across referring clinicians, SoC Service Teams, Clinical Navigators, and receiving Specialties. They are intended to illustrate how the guidance should be applied in common and challenging real-world situations, rather than to serve as prescriptive algorithms. The scenarios are illustrative and not exhaustive. They should be applied alongside clinical judgment, local operational realities, and patient-specific factors. In all cases, patient safety and clinical urgency take precedence over pathway considerations.

Scenario 1: Hematologic Presentations

Scenario 1A

Patient description: A 60-year-old presents with 6-8 weeks of drenching night sweats, intermittent fevers, unintentional weight loss, progressive non-tender cervical and axillary lymphadenopathy, fatigue, and CBC abnormalities (anemia with or without elevated WBC). The patient is clinically stable (no hemodynamic instability, no airway compromise).

Thought process: This presentation does not meet Immediate or Very Urgent criteria, as the patient is clinically stable without airway compromise or hemodynamic instability. The symptom pattern is strongly suggestive of lymphoma; however, at this stage diagnostic ownership is often fragmented because diagnosis depends on coordinated imaging and tissue strategy rather than a single predefined pathway entry. The referrer's role is to recognize lymphoma-pattern features, complete or attach available Tier 1 investigations, and refer promptly without delaying for non-directed tumour markers or specialty sequencing decisions. Given progressive B symptoms (fever, night sweats, weight loss), objective lymphadenopathy, and abnormal CBC findings, this presentation should be triaged as Urgent. The value of the SoC Service is to assume diagnostic ownership, coordinate Tier 2 imaging and biopsy sequencing, and actively navigate the patient to avoid common failure modes such as multiple referrals, delayed biopsy, and unclear accountability. The case exits the SoC Service once tissue diagnosis is established and the patient is transferred to hematology/oncology with a clearly identified receiving provider and plan.

Scenario 1B

Patient description: A 55-year-old has mild chronic anemia on routine labs, no B symptoms (fever, night sweats, weight loss), no lymphadenopathy, normal physical exam, and no progressive change in symptoms.

Thought process: There are no features requiring Immediate or Very Urgent assessment. This presentation does not meet criteria for the SoC Service because there is no clinical pattern suggestive of malignancy, no progression, and no objective findings beyond an isolated, low-specificity laboratory abnormality. The presentation does not raise cancer suspicion and has clear ownership within standard primary care evaluation. The appropriate next step is completion of a conventional anemia workup through usual care pathways, with monitoring for evolution rather than escalation to cancer-focused diagnostic coordination. This presentation would be categorized as Routine and is out of scope for SoC involvement at this time. The referral should be declined with clear guidance on re-referral criteria if anemia becomes progressive, remains unexplained after appropriate workup, or is associated with new symptoms, imaging abnormalities, or objective findings that raise concern for malignancy.

Scenario 1C

Patient description: A patient reports persistent fatigue and weight loss with abnormal CBC (e.g., cytopenia or cytosis) and has been unable to access timely investigations or follow-up due to lack of MRP/unattached status, geographic barriers, or repeated delays in imaging/specialist access.

Thought process: There are no features requiring Immediate or Very Urgent assessment. This presentation is appropriate for the SoC Service due to the combination of concerning symptoms and significant system-level risk factors. While the clinical pattern raises suspicion for malignancy, the defining feature is the elevated risk of harm from diagnostic delay due to lack of a Most Responsible Provider, access barriers, or repeated failure to complete investigations through usual pathways. In contrast to Scenario 1B, diagnostic ownership here is not functioning effectively despite ongoing concern. The referrer's decision point is not diagnostic certainty but recognition that standard care processes are failing this patient. Based on persistent symptoms, objective abnormalities, and compounded access risk, this presentation should be triaged as Urgent. The SoC Service adds value by accelerating completion of Tier 1 and Tier 2 investigations, coordinating sequencing, and maintaining diagnostic ownership until direction is clear. The case exits SoC once a diagnosis is established or responsibility is transferred to a specialty or service that can reliably act on results and follow-up.

Scenario 2: Abdominal and Pelvic Symptoms

Scenario 2A
Patient description: A patient presents with abdominal/flank pain and urinary symptoms; urinalysis shows hematuria; ultrasound demonstrates unilateral hydronephrosis (with or without a visible stone).

Thought process: This presentation does not meet Immediate or Very Urgent criteria, provided there is no sepsis, acute kidney injury, or uncontrolled pain, making outpatient diagnostic coordination potentially appropriate. The pattern raises concern for malignancy-related obstruction but also has plausible non-cancer explanations, and diagnostic ownership may fall between urology, imaging, and primary care depending on access and timing. The referrer should complete Tier 1 laboratory investigations while assessing whether urology access can occur within an acceptable timeframe. If access is timely and pathways are clear, direct referral is appropriate; if not, the SoC Service can add value by coordinating cross-sectional imaging and parallel routing. Given hydronephrosis and hematuria, this presentation should generally be triaged as Urgent unless symptoms are minimal and stable. The role of the SoC Service is to prevent diagnostic delay and fragmentation rather than replace urologic care. The case exits SoC once diagnostic ownership is assumed by urology or another appropriate specialty with a clear plan.

Scenario 2B
Patient description: A patient reports mild bloating; ultrasound shows a small adnexal cyst with non-cancer features; CA-125 is normal (if obtained appropriately); radiologist recommends repeat imaging in 6-12 months.

Thought process: There are no features requiring Immediate or Very Urgent assessment. This presentation does not meet the SoC Service criteria because imaging findings are low risk, a surveillance plan is already clearly defined, and diagnostic ownership is established through radiology-guided follow-up. There are no progressive symptoms, objective findings, or system barriers that would benefit from cancer-focused diagnostic coordination. The appropriate course is to follow the recommended surveillance plan rather than escalate care. This presentation is intentionally out of scope for SoC Service involvement. SoC Service referral may become appropriate only if interval progression, loss of clear diagnostic ownership, or new features emerge that raise cancer suspicion or coordination risk.

Scenario 3: Incidental Imaging Findings

Scenario 3A
Patient description: A CT performed for another indication (e.g., renal colic) shows retroperitoneal lymphadenopathy and an indeterminate solid liver lesion. The patient also reports fatigue and weight loss.

Thought process: This presentation does not meet Immediate or Very Urgent. The presence of multi-site incidental imaging abnormalities combined with systemic symptoms (fatigue and weight loss) creates diagnostic ambiguity and unclear disease-site ownership. This is a classic SoC Service use case, where coordinated decision-making is required to determine diagnostic sequencing and the safest, highest-yield biopsy strategy. The referrer should attach relevant imaging and complete the core Tier 1 panel where feasible, avoiding non-directed tumour markers. Given multi-site findings and associated systemic symptoms, this presentation should be triaged as Urgent. The SoC Service adds value by preventing fragmented referrals and delay. The case exits the SoC Service once tissue diagnosis is established or diagnostic responsibility is clearly transferred to the appropriate specialty.

Scenario 3B
Patient description: A patient has an incidental thyroid nodule (e.g., TI-RADS 3) identified on imaging, and the radiologist recommends repeat ultrasound at an appropriate interval.

Thought process: There are no acute safety concerns requiring Immediate or Very Urgent assessment. This presentation does not meet SoC Service criteria because malignancy risk is low, follow-up is explicitly defined, and diagnostic ownership is clear. There is no coordination gap or ambiguity requiring cancer-focused navigation. The appropriate action is adherence to the recommended surveillance plan with appropriate safety-netting. This presentation is intentionally out of scope for SoC Service involvement. Referral to the SoC Service should be considered only if interval growth, new suspicious imaging features, or emerging systemic symptoms create diagnostic ambiguity or coordination risk.

Scenario 4: Neurologic Symptoms

Scenario 4A

Patient description: A patient has tension-type headaches for several years, no progression or pattern change, normal neurologic examination, and no red/orange/yellow flag features.

Thought process: There are no Immediate, Very Urgent, or concerning neurologic red flags, and this presentation does not meet SoC criteria because symptoms are chronic, non-progressive, and lack features suggestive of malignancy. There is no diagnostic uncertainty related to cancer, no progression, and no role for cancer-focused diagnostic coordination. Management should proceed through non-cancer pathways with routine follow-up and return precautions. Importantly, even if symptoms were to evolve or worsen over time, this would not create an indication for SoC referral; progression of neurologic symptoms should prompt reassessment through appropriate neurologic or ED pathways rather than cancer-focused coordination. This scenario is Routine and intentionally included to reinforce that SoC is not designed to address diagnostic uncertainty or symptom evolution in the absence of cancer suspicion.

Scenario 4B

Patient description: A patient presents with new progressive headaches over weeks, gait instability, and personality/behaviour change, with a non-focal or normal exam; outpatient CT brain access is delayed beyond safe timelines.

Thought process: This presentation requires safety-based decision-making rather than default pathway referral. Progressive neurologic symptoms raise concern for serious pathology, and the determining factor is whether urgent imaging can be obtained safely outside the ED. If outpatient CT brain imaging can be completed within an appropriate and reliable timeframe, SoC Service coordination may be reasonable; if not, the patient should be directed to the ED to avoid unsafe delay. This presentation should generally be treated as Very Urgent unless rapid outpatient imaging is guaranteed. The SoC Service role, when appropriate, is limited to coordination after acute risk is mitigated. The SoC Service must never introduce delay in high-risk neurologic presentations. The case exits the SoC Service once CNS or disease-site ownership is established.

Scenario 5: Disease-Site-Specific Findings

Scenario 5A

Patient description: A patient has a palpable testicular mass; ultrasound confirms a solid intratesticular lesion; tumour markers are ordered/available and may be elevated.

Thought process: This presentation does not raise immediate safety concerns but meets disease-site pathway thresholds with clear diagnostic ownership. As such, it should not be routed through the SoC Service. The referrer's role is to initiate an **urgent, direct referral to urology**, as SoC diagnostic coordination would add an unnecessary step and risk delay. This presentation is intentionally **out of scope for SoC diagnostic coordination**. Any SoC involvement, if required, should be **limited to targeted support to facilitate timely investigations or access** (e.g., expediting imaging or procedures).

Scenario 5B

Patient description: A patient in their 60s has a solid renal mass identified on appropriate imaging, with basic labs already completed.

Thought process: There are no Immediate safety concerns, and this presentation meets disease-site thresholds with clear ownership and a defined diagnostic trajectory. Direct referral to urology is the appropriate action, and SoC Service involvement would not add value. This presentation is Urgent but out of scope for SoC diagnostic coordination. The SoC Service should not be involved in established disease-site pathways except to mitigate access barriers that risk delay. Diagnostic responsibility should remain with urology from the outset.

Scenario 6: Clinical Deterioration

Scenario 6
Patient description: A patient referred to the SoC Service for anemia/weight loss/abdominal bloating is contacted 24-48 hours later and reports worsening abdominal pain, distension, and obstipation.

Thought process: This scenario illustrates that clinical status always overrides pathway-based coordination. Worsening abdominal pain, distension and obstipation raise concern for acute pathology requiring immediate evaluation. The appropriate action is urgent ED assessment rather than continued outpatient coordination, regardless of referral status. This presentation meets Immediate criteria due to the risk of bowel obstruction and potential instability. The role of the SoC Service, navigator, or referrer is to direct urgent care and communicate relevant findings to support timely management. SoC coordination should pause until acute issues are addressed, reinforcing that patient safety supersedes pathway logic.

Glossary

Abdominal Mass An abnormal lump in the abdomen that may indicate malignancy or another serious condition
Access Barriers Factors that limit a patient's ability to complete diagnostic assessment, including geographic, financial, social, or system challenges
Acute Leukemia A rapidly progressing cancer of the blood and bone marrow requiring urgent assessment
Airway Obstruction Partial or complete blockage of the airway that may cause respiratory distress and requires urgent evaluation
Alpha-Fetoprotein (AFP) A tumour marker used in the evaluation of certain cancers, including hepatocellular carcinoma and germ cell tumours (testicular, ovarian, and extragonadal).
Anemia A condition characterized by low hemoglobin levels, which may indicate bleeding, malignancy, or other underlying disease
Ascites Abnormal accumulation of fluid in the abdomen, often associated with malignancy or liver disease
Axillary Lymph Nodes Lymph nodes located in the armpit region that may be enlarged in breast or other cancers
Beta-Human Chorionic Gonadotropin (β-hCG) A tumour marker used in the evaluation of certain cancers, including germ cell tumour
Biopsy The removal of tissue for diagnostic examination to confirm or rule out cancer
Bladder Mass An abnormal growth in the bladder that may indicate malignancy
Bone Scan A nuclear imaging test used to detect bone metastases or other abnormalities
B-Symptoms Systemic symptoms such as fever, night sweats, and weight loss commonly associated with malignancy
Breast Mass A palpable or imaging-detected abnormality in the breast requiring diagnostic evaluation
Cancer Screening Testing performed in asymptomatic individuals to detect cancer early, not part of SoC scope
Central Lung Mass A mass located near the central airways, often associated with higher risk of airway compromise
Clinical Judgment The application of professional expertise to guide diagnostic and management decisions
Clinical Ownership Responsibility for ongoing diagnostic decision-making and patient management
Complete Blood Count (CBC) A blood test used to evaluate overall health and detect abnormalities such as anemia or infection
Computed Tomography (CT) Advanced imaging that provides detailed cross-sectional views of the body
Constitutional Symptoms Non-specific symptoms such as fatigue, weight loss, or fever that may indicate serious illness
Coordinated Routing The process of directing patients to the most appropriate service or specialty
Cystoscopy A procedure used to examine the bladder and obtain biopsies if needed
Diagnostic Assessment Program (DAP) Disease-site-specific programs that provide coordinated diagnostic evaluation for suspected cancer
Diagnostic Direction The working clinical understanding used to guide next steps (not a confirmed diagnosis)
Diagnostic Ownership Transfer Formal handoff of responsibility for diagnostic care to another provider or service
Dyspnea Shortness of breath, which may indicate respiratory or cardiac pathology
Emergency Department (ED) Acute care setting for immediate or very urgent assessment
Endobronchial Ultrasound (EBUS) A procedure used to biopsy lung and mediastinal structures
Endometrial Biopsy A procedure to sample the lining of the uterus for diagnostic evaluation
Equity-Deserving Communities Populations experiencing systemic barriers to accessing care
Escalation Increasing urgency or level of care due to clinical deterioration or risk
Exit Criteria Defined conditions for transition out of the SoC Service
First Appropriate Service/Specialty The most suitable service to assume diagnostic responsibility
Hematuria Presence of blood in the urine, which may indicate malignancy or other pathology
Hemoptysis Coughing up blood, which may indicate lung cancer or other serious conditions
Hematologic Malignancy Cancer originating in blood-forming tissues such as leukemia or lymphoma
Hypercalcemia Elevated calcium levels in the blood, which may be associated with malignancy
Hyperleukocytosis Markedly elevated white blood cell count, often seen in leukemia
Imaging-Led Suspicion of Cancer Concern for malignancy based primarily on imaging findings

Immediate Presentation A clinical scenario requiring assessment within hours due to risk of harm
In Scope Presentation A clinical scenario appropriate for SoC referral
Intake The initial phase of SoC involvement following referral acceptance
Lactate Dehydrogenase (LDH) A blood marker that may be elevated in certain cancers
Level 1 Support Provider-facing consultative guidance without patient intake
Level 2 Support Time-limited coordination to facilitate routing or access
Level 3 Support Full navigation and diagnostic coordination by the SoC Service
Lymphadenopathy Enlargement of lymph nodes, which may indicate infection or malignancy
Magnetic Resonance Imaging (MRI) Advanced imaging modality providing detailed soft tissue visualization
Most Responsible Provider (MRP) The clinician accountable for patient care at a given time
Navigation Coordination of care to support timely diagnosis and follow-up
Non-Site-Specific Symptoms Symptoms that do not localize to a specific organ or disease site
Out of Scope Presentation A clinical scenario not appropriate for SoC referral
Ovarian Mass An abnormal growth in the ovary that may indicate malignancy
Pathologic Fracture A bone fracture occurring due to underlying disease such as cancer
Peritonitis Inflammation of the abdominal lining, often requiring urgent care
Pleural Effusion Accumulation of fluid around the lungs, which may indicate malignancy
Prostate-Specific Antigen (PSA) A blood test used in the evaluation of prostate conditions, including cancer
Psychosocial Barriers Emotional, social, or practical factors that affect engagement in care
Redirection Routing a patient to a more appropriate service or pathway
Referral Acceptance Formal acceptance of a patient into the SoC Service
Referral Rejection Determination that a referral is not appropriate for SoC, with alternative guidance provided
Renal Mass An abnormal growth in the kidney that may indicate malignancy
Safety-Netting Instructions provided to patients on when and how to seek care if symptoms worsen
Sarcoma A type of cancer arising from connective tissues such as muscle or bone
Sepsis A life-threatening response to infection requiring urgent treatment
SoC Service (Suspicion of Cancer Service) A coordinated diagnostic service for patients with suspected cancer
Spinal Cord Compression Pressure on the spinal cord, often due to malignancy, requiring urgent intervention
Standard Cancer Workup A time-sensitive but non-accelerated diagnostic process
Superior Vena Cava (SVC) Syndrome Obstruction of blood flow through the SVC causing swelling and respiratory symptoms
Symptom Clusters Groupings of symptoms used to guide diagnostic pathways
Testicular Mass An abnormal growth in the testicle that may indicate malignancy
Tier 1 Investigations Initial, commonly available tests used for triage and referral decisions
Tier 2 Investigations More advanced tests used to clarify diagnosis and guide routing
Timely Action Execution of diagnostic steps within defined timeframes
Triage Assessment of referral information to determine urgency and next steps
Tumour Markers Substances in blood or tissue that may indicate the presence of cancer
Urgent Cancer Workup Accelerated diagnostic process (typically within 7-14 business days)
Very Urgent Presentation A clinical scenario requiring assessment within 48 hours
Warm Handoff Structured transfer of care with clear communication and accountability

Appendix A: Select Adjunct Tumour Markers in Suspicion of Cancer

These tumour markers may be used selectively when clinical presentation or imaging suggests a specific tumour phenotype or organ of origin. They are not recommended for routine ordering in all Suspicion of Cancer presentations. Results must always be interpreted in conjunction with clinical assessment, imaging, and pathology.

Tumour Marker	Indication	Flags/ Considerations	Range Normal/Elevated Thresholds	OHIP Coverage/ Out Of Pocket Cost (OOP)
CA-125	Symptom-led or SoC-patterned gynecologic origin (ovarian/pelvic mass with suspicion of primary ovarian cancer, peritoneal masses/omental caking, ascites) particularly in postmenopausal women. Adjunct to target gynecologic evaluation/imaging and monitor course/response.	Not recommended for routine diagnostic workup or screening, and not appropriate as stand-alone confirmation of ovarian origin; interpretation requires correlation with pathology and imaging.	≤35 U/mL = "normal"	OHIP: Insured test when ordered by an authorized practitioner via approved requisition. OOP: $30-40
PSA	Suspected prostate primary cancer, including individuals with a prostate (or post-prostatectomy) over 40 years with adenocarcinoma SOC, and individuals of any age with bone or multisite metastases consistent with possible prostate cancer metastases. Elevated PSA or PSA-positive IHC aligned with a prostate-compatible metastatic pattern (e.g., blastic bone lesions) may guide management. PSA may also be used longitudinally to assess disease course.	Not intended for routine testing in all Suspicion of Cancer (SOC) presentations. PSA alone is insufficient to establish a prostate primary; confirmation requires pathology/immunohistochemistry and clinical or radiologic correlation (e.g., NKX3.1 expression, prostate-compatible metastatic pattern). Additional diagnostic investigations (e.g., repeat PSA, prostate MRI, PSMA-directed imaging, or biopsy) should not be pursued when results are unlikely to change management...	4 ng/mL = "normal"	OHIP: Insured if either of the following apply: Diagnosed with prostate cancer and receiving treatment or following up after receiving treatment Healthcare provider suspects prostate cancer based on history and/or the results of physical examination (including digital rectal examination) OOP: $30-100
CEA	Suspected gastrointestinal primary; adjunct marker to help track disease course and treatment response in GI-suspected presentations.	Not diagnostic for GI origin and not appropriate as tumour-type-specific confirmation; elevations require interpretation alongside clinical, pathological, and imaging findings.	CEA >10 ng/mL: suggestive beyond benign CEA >20 ng/mL: strongly suggests active malignancy/recurrence CEA >100 ng/mL: often metastatic	OHIP: Insured when carried out in accordance with Cancer Care Ontario guidelines, and not as a general cancer screen. OOP: $35
CA 19-9	Suspected GI or pancreaticobiliary primary: adjunct marker used when presentation/histology suggests a GI/pancreaticobiliary possibility, to support directed workup and to determine disease course/monitor treatment response.	Not diagnostic and not appropriate as proof of GI/pancreaticobiliary origin; avoid anchoring on this result in isolation and interpret only with clinical, pathological, and radiologic correlation.	≤37 U/mL	OHIP: Insured test when ordered by an authorized practitioner via approved requisition OOP: $50

Tumour Marker	Indication	Flags/ Considerations	Range Normal/Elevated Thresholds	OHIP Coverage/ Out Of Pocket Cost (OOP)
LDH	Suspected/confirmed advanced melanoma or lymphoma: include serum LDH as part of baseline work-up for prognostication/risk stratification; elevated LDH may guide the appropriateness/ intensity of further investigations (e.g., staging) and systemic treatment and may be followed longitudinally to assess disease course/response.	Not diagnostic of tissue of origin; LDH is non-specific and should be interpreted only with clinical, imaging, and pathology context. Use primarily for prognostication—elevated LDH is a poor-prognosis feature that may guide the extent of further investigations and treatment intensity.	140 to 280 U/L = "normal"	OHIP: Insured test when ordered by an authorized practitioner via approved requisition OOP: $30-50
AFP (hepatic)	Suspected hepatocellular carcinoma (HCC) / primary liver origin: AFP when presentation is compatible with HCC (e.g., liver-dominant disease), particularly in the setting of risk factors (cirrhosis, other liver risk factors) where AFP and imaging is diagnostic of hepatocellular carcinoma. Adjunct to support targeted hepatobiliary evaluation and monitor course/response.	Not recommended for routine diagnostic workup or screening, and not appropriate as stand-alone confirmation of liver origin; interpret only with clinical context and hepatobiliary imaging	5-10 ng/mL = "normal"	OHIP: Insured test when ordered by an authorized practitioner via approved requisition OOP: $138-165
AFP - (Testicular or Ovarian Germ Cell Tumour)	Suspected germ cell tumours of testes or ovaries: used with β-hCG when presentation suggests germ cell origin (e.g., mediastinal nodes, retroperitoneal mass, or ovarian mass [age <30; where relevant gonads are present]). Elevation (AFP or β-hCG) informs targeted evaluation—testicular ultrasound (if testes present) or pelvic/ovarian work-up (if ovaries present)	Not intended for routine testing in all suspected SOC/CUP; use only when the clinical presentation suggests a germ cell tumour phenotype. AFP (with β-hCG) is supportive—not diagnostic in isolation—and should be interpreted alongside imaging and pathology, recognizing AFP can be elevated in non-germ cell conditions (e.g., hepatocellular disease).	<20 ng/mL can be mildly elevated and non-rising; decisions to treat should not be based solely on AFP values. ≥1,000 ng/mL (ESMO S2 threshold) >10,000 ng/mL (ESMO S3 threshold)	OHIP: Insured test when ordered by an authorized practitioner via approved requisition OOP: $165
β-hCG (beta-human chorionic gonadotropin) — (Germ Cell Tumour - Testes or Ovary)	Suspected germ cell tumour (testes or ovaries): used with AFP when adenocarcinoma with mediastinal nodes (<50, testes present), retroperitoneal mass (<65, testes present), or ovarian mass (age <30, ovaries present) suggests germ cell origin. Elevation (β-hCG or AFP) informs targeted imaging—testicular ultrasound (if testes present) or appropriate pelvic/ovarian evaluation (if ovaries present). Also considered (not routinely) in	Not intended for routine testing across all SOC. β-hCG is not diagnostic in isolation; indiscriminate ordering is discouraged and further investigation should be limited to scenarios where results will affect treatment decisions.	BORDERLINE FLAGS Mildly elevated (generally <20 IU/L) → further evaluation should be considered before initiating treatment because non-tumour causes may occur (e.g., pregnancy, recent pregnancy loss, pituitary hCG in peri/post-menopausal individuals).	OHIP: Insured test when ordered by an authorized practitioner via approved requisition β-hCG / beta subunit must be specifically requested OOP: $39 - 138

Tumour Marker	Indication	Flags/ Considerations	Range Normal/Elevated Thresholds	OHIP Coverage/ Out Of Pocket Cost (OOP)
	patients with midline disease/brain metastases when presentation is compatible with germ-cell tumours, alongside AFP.		Pregnancy should be excluded in individuals with a uterus of reproductive potential before attributing elevation to malignancy. MARKED ELEVATION FLAGS (levels consistent with clinically significant elevation; used in staging/risk frameworks) - ≥5,000 IU/L (ESMO S2 threshold) - >50,000 IU/L (ESMO S3 threshold)	

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APPENDIX B. Symptom-Based Quick Reference for Tier 1 Suspicion of Cancer (SoC) Workup and Referral

NON-SITE-SPECIFIC SOC PRESENTATIONS

LEUKEMIA-PATTERN/CYTOPENIA -CYTOSIS

FEATURES: Anemia; Cytoses (e.g., leukocytosis, thrombocytosis, erythrocytosis); Cytopenias (e.g., leukocytopenia, thrombocytopenia, pancytopenia); B symptoms (fever, night sweats, weight loss)

TIER 1: CBC; RFP; LFT; CRP; Urinalysis; Chest X-ray if cardiopulmonary symptoms or abnormal physical exam

LYMPHOMA-PATTERN

FEATURES: Lymphadenopathy; Splenomegaly; B symptoms (fever, night sweats, weight loss); Cytopenias (e.g., leukocytosis, thrombocytosis) or cytoses

TIER 1: CBC; RFP; LFT; CRP; Urinalysis; Ultrasound of lymph nodes and/or spleen, based on physical examination findings; Chest X-ray if cardiopulmonary symptoms or abnormal physical exam

MDS / MPN / MYELOMA-PATTERN

FEATURES: Splenomegaly; Bone pain or lytic bone lesions without clear benign cause; Mild-moderate cytopenias; Cytoses (e.g., thrombocytosis, erythrocytosis, or eosinophilia); Mild hypercalcemia; Chronic or worsening renal dysfunction

TIER 1: CBC; RFP; LFT; CRP; Urinalysis; Ultrasound lymph nodes and/or spleen, based on physical examination findings; Bone profile (calcium); Targeted X-ray for focal bone pain; Chest X-ray if cardiopulmonary symptoms or abnormal physical exam

BONE PAIN (LONG BONE OR SPINE)

FEATURES: Pain with weight-bearing; Suspected pathologic fracture; Motor or sensory deficit; Back pain with neurologic features; New bowel or bladder dysfunction

TIER 1: CBC; RFP; LFT; CRP; Urinalysis; Bone profile (calcium); Targeted X -ray of the symptomatic area

FATIGUE

FEATURES: Persistent, unexplained fatigue not relieved by rest; functionally impairing

TIER 1: CBC; RFP; LFT; CRP; Urinalysis; TSH; Chest X-ray only if cardiopulmonary symptoms

NEUROLOGIC SYMPTOMS (SUBACTUTE)

FEATURES: New or different headaches ; Persistent headaches not resolving with usual therapy; Headaches with focal neurologic symptoms (e.g., gait change, personality/behaviour change); Headache without an emerging diagnostic pattern after ≥2 weeks; Symptoms suggestive of paraneoplastic neurologic syndromes (when appropriate)

TIER 1: CBC; RFP; LFT; CRP; Urinalysis; Non-contrast CT head

WEIGHT LOSS

FEATURES: Unintentional, unexplained ≥10% body weight loss

TIER 1: CBC; RFP; LFT; CRP; Urinalysis; TSH; Chest X-ray if cardiopulmonary symptoms or anormal physical exam

ABDOMINAL OR PELVIC PAIN

FEATURES: Persistent abdominal pain with no etiology; Persistent pelvic pain with no etiology

TIER 1: CBC; RFP; LFT; CRP; Urinalysis; Ultrasound of abdomen or pelvis

ABNORMAL/SIGNIFICANT INCIDENTAL IMAGING

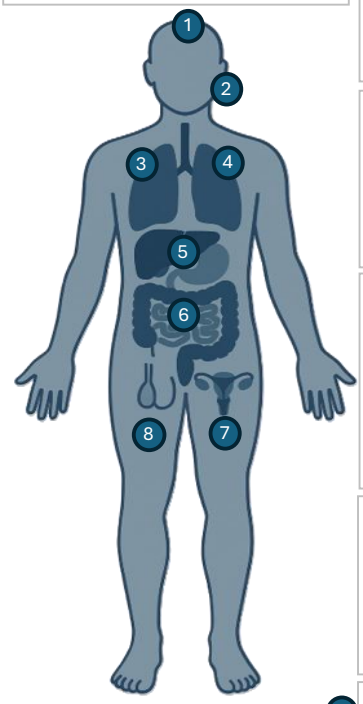
FEATURES: Suspicious imaging finding for malignancy; Incidental imaging finding reported as indeterminate or suspicious with no documented follow-up plan; Metastatic-pattern (diffuse or multi-focal) imaging without a clear primary tumour

TIER 1: CBC; RFP; LFT; CRP; TSH; Urinalysis; Tumour markers: **ONLY** when imaging suggests an organ-specific primary/metastatic pattern (Appendix C)

1 HEAD & NECK

FEATURES: Neck mass or cervical lymphadenopathy (visible or palpable); Persistent oral or oropharyngeal lesion (e.g., non-healing ulceration or unexplained mucosal bleeding); Cranial nerve abnormality; Persistent upper aerodigestive symptoms: dysphagia, odynophagia, dysphonia, otalgia, or throat pain with non-malignant causes ruled out; Systemic symptoms: unexplained weight loss, fever, night sweats; Thyroid nodule or mass with concerning features

TIER 1:Ultrasound neck; Chest X-ray



2 SKIN/SOFT TISSUE

FEATURES: **Cutaneous/Skin/mucosal /nail bed:** suspicious pigmented or amelanotic skin lesion with concerning ABCDE features, bleeding, or ulceration, evidence of cutaneous or subcutaneous satellite lesions in the vicinity of the primary skin lesion, palpable lymphadenopathy associated with a skin lesion. **Soft tissue:** palpable soft-tissue mass (extremity, trunk, head, neck) that is: larger than 5cm or demonstrates one or more features: rapid growth, pain, recurrence after removal, fixation to deep structures (bone, fascia, joint, 3-5 cm mass that is located directly over bone, or in popliteal, groin, antecubital, axillary regions

TIER 1: **Cutaneous**: Punch biopsy or excisional biopsy of the primary skin lesion, imaging: If palpable lymphadenopathy is present, ultrasound of the affected nodal basin. **Soft tissue:** Ultrasound of the area of concern; X-ray (plain radiograph) of the area if the mass is fixed to bone or joint

3 BREAST

FEATURES: Palpable breast mass; New-onset Breast asymmetry; Unilateral spontaneous nipple discharge or nipple retraction; Skin changes (redness, edema) in absence of infection; Palpable axillary mass or neck mass, with associated breast symptoms

TIER 1: Bilateral mammogram (digital); Breast/axillary ultrasound

4 CHEST/LUNG

FEATURES: Persistent hemoptysis (unresponsive to treatment or of unknown cause); Unresolving pneumonia with imaging concerning for lung cancer; Suspicious thoracic imaging findings (lung or pleural nodules/masses, pleural effusion, mediastinal or hilar lymphadenopathy); Other persistent aerodigestive symptoms (e.g., hoarseness, stridor, superior vena cava syndrome)

TIER 1: Chest X-ray or diagnostic chest CT (within 3 months of referral, or updated for new or worsening symptoms)

5 HEPATOPANCREATICOBILIARY

FEATURES: Jaundice, clinical or biochemical (total bilirubin >80 µmol/L), with associated pruritus, dark urine, or light-coloured stool; Ascites; Persistent upper abdominal pain or central back pain; Unintentional, unexplained weight loss; Symptoms of gastric outlet obstruction (anorexia, early satiety, nausea, vomiting)

TIER 1: CBC; RFT; LFT; Abdominal ultrasound

6 LUMINAL GASTROINTESTINAL (UPPER and LOWER)

FEATURES: **Upper GI Tract (Esophagus, stomach, duodenum):** New or worsening dysphagia or dyspepsia; signs of gastrointestinal bleeding, including hematemesis, melena, iron-deficiency anemia; Symptoms of gastric outlet obstruction (early satiety; new or worsening upper abdominal pain; anorexia with reduced intake; nausea; vomiting); unintentional unexplained weight loss or malnutrition; abdominal distention **Lower GI Tract (Small intestine, colon, rectum, anus):** Signs of gastrointestinal bleeding, including rectal bleeding, melena, iron-deficiency anemia; change in bowel habits, including new or worsening constipation or diarrhea, abdominal distention; palpable mass, including abdominal mass, rectal or anal mass; perianal symptoms associated with a mass, including pruritus (itching) or pain; unintentional, unexplained weight loss

TIER 1: CBC, RFP; LFT; Iron studies; Physical examination: Digital rectal examination, Inguinal lymph node examination, as appropriate

7 GYNECOLOGY

FEATURES: **Ovarian:** solid ovarian mass, ascites with peritoneal thickening, omental caking, bloating; **Endometrial:** abnormal vaginal bleeding (including post-menopausal bleeding), lower back pain or pelvic pain; ascites; omental caking or peritoneal disease; profuse vaginal discharge **Cervical:** contact bleeding, cervical mass; sciatic or lower back pain; copious vaginal discharge; new-onset pelvic pain; unilateral leg swelling in the absence of DVT **Vaginal/Vulvar:** bleeding or painful mass, persistent ulcer; enlarged inguinal lymph nodes TIER 1: Abdominal and pelvic examination; Urinalysis; Pelvic ultrasound (as appropriate). CBC; Iron studies for patients with bleeding

8 GENITOURINARY

FEATURES: **Testes:** testicular mass, ± retroperitoneal or mediastinal nodal mass; **Prostate:** abnormal digital rectal exam suggesting mass; elevated PSA; urinary retention; pelvic pain; hematospermia; bone pain; **Bladder:** hematuria (gross or microscopic), lower abdominal or pelvic pain, dysuria; **Kidney:** renal mass (incidental or symptomatic), flank pain, hematuria, hydronephrosis**; Penis:** penile mass, ± bleeding, pain, inguinal lymphadenopathy

TIER 1: Physical Examination: External genital examination (testes, inguinal lymph nodes), digital rectal examination, or an appropriate imaging alternative; Imaging: **Testes:** Ultrasound of the testes ± ultrasound of the inguinal nodal basin; **Prostate**: Do not order prostate ultrasound for elevated prostate-specific antigen (PSA) alone, prostate ultrasound should be reserved for patients with urinary symptoms; **Bladder:** Pelvic ultrasound (first line for suspected bladder mass or hydronephrosis); **Renal:** Ultrasound or CT KUB (for suspected renal mass, hematuria or hydronephrosis)

This diagram is provided for decision-support purposes only to assist with pattern recognition and referral routing. Clinical judgment and applicable clinical guidance must be applied in all cases.

Ontario Health

Appendix C: Patient Resources

Suspicion of Cancer (SOC) Clinic Warm Transfer of Care Summary for: Patients and Families

Clinic: SOC clinic [contact information]

Date: Click or tap to enter a date.

Patient Name: Click or tap here to enter text.

What we looked at:

- [Reason the patient was referred to the SOC Clinic]
- [Tests and assessments completed]

What we found so far:

- [Summary of findings, in plain language]

What happens next:

- [Next service or clinic that the patient is referred to OR a summary of the monitoring plan and who is accountable to the patient]
- [Name of new doctor (if known)]
- [Appointment date or how this will be arranged]

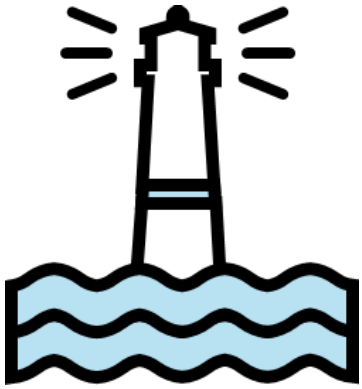
Tests pending (if any):

- [Test(s)]
- [What the test is for]
- [Who will follow-up on results]

Important information for you:

- Who is responsible for your care
- Who to contact if you have questions
- Seek urgent care if you have:
    - new or worsening symptoms
    - severe pain, shortness of breath, bleeding, or sudden change in how you feel

The Suspicion of Cancer Clinic



What is the Suspicion of Cancer (SOC) clinic?

The SoC clinic is a service that helps find the **cause** of your symptoms or test results. Being referred to the SoC clinic **does not mean you have cancer**. It means **more checks are needed** to find out what is causing your symptoms. The clinic may arrange tests, such as blood tests or scans, to help find the cause, including cancer or other health problems.

The SOC clinic will help make the diagnostic process more coordinated by:

- Making sure the **right tests** are ordered
- **Coordinating next steps**, so you are not left waiting or wondering what to do next
- Improving access to care as **close to home** as possible
- Supporting a **better experience** for you, your family, or your care partner

What does this mean for you?

- Your symptoms are being **taken seriously**
- The goal is to **find answers sooner**
- You will have **guidance and support** throughout all steps

How SOC works:

- You will be **referred** to the SOC clinic by your family doctor, walk-in clinic, or hospital team.
- You will be connected to a SOC **Navigator**. Your navigator will be your one main contact at the clinic. They will provide culturally safe care, support for your unique needs, and **explain what will happen at each step**.
- Your navigator will arrange any **follow-up tests** that you need. Where possible, tests will be arranged to **limit your travel** to clinics.
- Once your tests are done, the SOC clinical **team will review your results**.
- If you are diagnosed with cancer or if it is still suspected, your navigator will arrange **next steps and follow-up care** if needed.
- If cancer is ruled out, your navigator will arrange any **other care or tests** that you need.

CONTACT: _____
ON YOUR SOC CARE TEAM FOR MORE INFORMATION.

You have been referred to the Suspicion of Cancer Clinic

During your emergency visit, you had symptoms or test results that need to be examined further. To help you get the **right follow-up care**, you have been referred to the **Suspicion of Cancer (SOC) Clinic.**

IMPORTANT TO KNOW

Being referred to the **SoC Clinic does not mean you have cancer**.

- Sometimes patients have other conditions that need care or follow-up.
- The referral helps organize the right tests and specialists in one coordinated process.
- Inform your family doctor (if you have one) about your visit and planned follow-up.

When to Return to the Emergency Department

Please return to the emergency department immediately if you experience:

- severe or worsening pain
- difficulty breathing
- bleeding that will not stop
- vomiting that will not stop
- new or worsening symptoms that concern you

Questions About Your Referral

If you have questions about your referral or upcoming tests, please contact the SOC Clinic.

What is the Suspicion of Cancer Clinic?

The SOC clinic helps you get access to tests when your doctor thinks that your symptoms or test results may be caused by cancer. Being referred does not mean you have cancer; it means further testing is needed.

What Happens Next?

Depending on your needs, the clinic may arrange:

- Imaging tests – for example, a CT scan or ultrasound
- More blood or lab tests
- An appointment or testing with a specialist

Your Next Steps

Please make sure the hospital has your up-to-date contact details, including:

- Phone number
- Voicemail availability
- Another way to contact you (such as a care partner's phone number)

You will receive a call from the SOC clinic within 2 business days of your Emergency Department discharge. These calls may come from unknown or hospital numbers and can include important updates about your care.

If you have **not** been contacted within 2 business days of your emergency visit, please contact the SOC clinic.

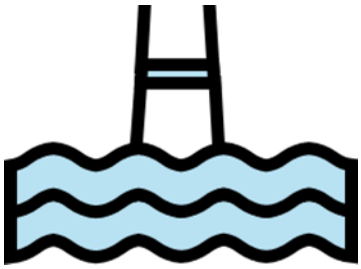
Clinic Contact Information

Location: _____

Phone: _____

Email (if applicable): _____

Suspicion of Cancer (SOC) Clinic
Warm Transfer of Care Summary for:
Patients and Families



Clinic: SOC clinic [contact information]

Date:

Patient Name:

What we looked at:

- [Reason the patient was referred to the SOC Clinic]
- [Tests and assessments completed]

What we found so far:

- [Summary of findings, in plain language]

What happens next:

- [Next service or clinic that the patient is referred to OR a summary of the monitoring plan and who is accountable to the patient]
- [Name of new doctor (if known)]
- [Appointment date or how this will be arranged]

Tests pending (if any):

- [Test(s)]
- [What the test is for]
- [Who will follow-up on results]

Important information for you:

- Who is responsible for your care
- Who to contact if you have questions
- Seek urgent care if you have:
    - new or worsening symptoms
    - severe pain, shortness of breath, bleeding, or sudden change in how you feel

Need this information in an accessible format?
1-877-280-8538, TTY 1-800-855-0511, info@ontariohealth.ca.

Document disponible en français en contactant info@ontariohealth.ca